South Carolina External Quality Review

COMPREHENSIVE TECHNICAL REPORT FOR CONTRACT YEAR '17-18

Submitted: August 27, 2018

Prepared on behalf of the
South Carolina Department
of Health and Human Services

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EXECUTIVE SUMMARY

The Balanced Budget Act of 1997 (BBA) requires each State Medicaid Agency that contracts with Managed Care Organizations (MCOs) to evaluate compliance with the state and federal regulations in accordance with *42 Code of Federal Regulations (CFR) 438.358*. To meet this requirement, the South Carolina Department of Health and Human Services (SCDHHS) executed a contract with The Carolinas Center for Medical Excellence (CCME), an External Quality Review Organization (EQRO), to conduct an External Quality Review (EQR) for all MCOs participating in the Healthy Connections Choices and Health Connections Prime Programs.

The EQR verifies that Medicaid members receive quality health care through a system that promotes timeliness, accessibility, and coordination of services. CCME conducted three mandatory activities for each health plan: validation of performance improvement projects (PIPs), validation of performance measures (PMs), and an evaluation of compliance with state and federal regulations. This report is a compilation of the 2017-2018 individual annual review findings for:

- Select of South Carolina (Select)
- Absolute Total Care (ATC)
- BlueChoice HealthPlan of South Carolina (BlueChoice)
- Molina Healthcare of South Carolina (Molina)
- WellCare of South (WellCare)
- SC Solutions (Solutions)

A. Overall Findings

An overview of the findings for each section follows. Additional information regarding the reviews, including strengths, weaknesses, and recommendations, is included in the narrative of this report.

Administration

ATC, Molina, Select and WellCare demonstrated 100% compliance to the standards in the Administrative Section, which addresses staffing, management information systems, compliance and program integrity, and confidentiality. BlueChoice demonstrated 87% compliance to the standards—a "Not Met" score was received in the compliance/program integrity section because of uncorrected deficiencies identified during the previous EQR.

Provider Services

All five plans have established programs and processes that address review areas such as credentialing/recredentialing, network evaluation, provider education, practice guidelines, continuity of care, and medical record review. All plans were required to make changes to their policies and program materials because of insufficient and incorrect information. For credentialing/recredentialing, common issues included not

querying the *Termination for Cause List* and/or the *Social Security Death Master File* (SSDMF). Behavioral health credentialing/recredentialing files for two plans did not address hospital arrangements for providers who may need to refer a patient in crisis for admission. Two plans had outdated materials or broken weblinks related to preventive/clinical practice guidelines. Other individual plan issues were related to Credentialing Committees lacking a quorum and failure to measure appointment access at the provider level.

Member Services

The health plans have comprehensive member education processes using a variety of forums including member handbooks, mailed materials, websites, etc. Common issues include errors in benefit information such as covered/excluded services and service limitations (ATC, Molina) and errors, omissions, and discrepancies in copayment information (ATC, BlueChoice, Molina). None of the plans meet the NCQA target response rate of 40.0% for both the adult and child CAHPS surveys; only three of the five plans (ATC, BlueChoice, and Molina) meet requirements for the number of valid responses for both adult and child surveys. Grievance documentation and handling continue to be problematic for most plans.

Quality Improvement

All the plans have program descriptions and policies as evidence that the programs are designed to provide the structure and key processes for improving care and services available to members and providers. The Board of Directors (BOD) for each plan has delegated the authority and responsibility for its Quality Improvement (QI) programs. CCME's review of committee minutes found each quality committee met regularly, and minutes of the committee decisions were well documented.

Health plans are required to have an ongoing program of Performance Improvement Projects (PIPs) and report plan performance using Healthcare Effectiveness Data and Information Set (HEDIS®) measures applicable to the Medicaid population. To evaluate the accuracy of the performance measures (PMs) reported, CCME uses the *Centers for Medicare & Medicaid Services (CMS) Protocol, Validation of Performance Measures*. This validation method balances the subjective and objective parts of the review, outlines a review process that is fair to the plans, and provides the State information about how each plan is operating. All plans are using a HEDIS® certified vendor or software to collect and calculate the measures. All five MCOs CCME reviewed are fully compliant.

CCME validated ten projects for the five MCOs. Of the ten projects, six were scored in the high confidence range and four projects were scored in the confidence range. There were no projects considered to be in the low confidence or not credible range. CCME found varying issues with PIP reporting across the plans. Such issues included lack of data analysis to support study rationale, incorrect data methodology reporting, lack of

information regarding staff/personnel involved in data collection and calculation, inappropriate reporting on benchmark and baseline goal rates, and lack of improvement in the measures of interest.

Overall, the plans performed well in the Quality Improvement section. BlueChoice was not monitoring provider compliance with clinical and preventive practice guidelines. BlueChoice and Molina had projects that did not meet the validation requirements.

Utilization Management

Each of the health plans has a Utilization Management (UM) program description and UM policies that provide staff with specific requirements and detailed processes for conducting UM functions. CCME's review of these information sources, including Member Handbooks, Provider Manuals, etc., revealed errors, discrepancies, and information omissions. CCME's review of UM approval and denial files confirmed the plans conduct most processes appropriately; however, some *Notice of Adverse Benefit Determination* letters do not include all necessary or required information.

Appeal process documentation and appeal files revealed numerous issues related to definitions of appeal terminology, outdated forms, incomplete information regarding member representatives in the appeal process, errors in appeal filing and resolution timeframes, and errors in information about benefit continuation during appeals processes. Despite these documentation issues, CCME's review of appeals files confirmed that appropriate appeals handling processes and requirements are followed.

Each of the health plans has well-developed and implemented Case Management (CM) programs. BlueChoice has not designated a Transition Coordinator to meet the requirement found in the *SCDHHS Contract, Section 5.6.2*. CCME's CM file review for all plans confirmed appropriate CM processes are followed and appropriate functions are conducted. All the plans have processes to measure member satisfaction with case management.

The *SCDHHS Contract, Section 8.4.2.7*, requires the health plans to develop a preferred provider program based on quality; however, Select provided no evidence of compliance with this requirement.

Delegation

Each of the MCOs has established policies that define requirements and processes for delegating MCO functions to other entities. The health plans use delegation oversight audit tools to monitor and oversee delegate performance. Several issues were noted in policies and oversight tools, particularly surrounding delegated credentialing requirements and queries. Documentation of delegation oversight activities also revealed issues, including use of incorrect audit tools, errors and inconsistencies in scoring, failure

to conduct all required oversight activities, and oversight conducted without considering all South Carolina specific requirements.

State Mandated Services

All required core benefits are provided by each of the plans. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Programs provided by all the plans ensure mandated services are provided to members from birth through the month of their 21st birthday. The plans monitor provider compliance to the EPSDT programs.

During the previous EQR, each of the plans submitted quality improvement plans to address identified deficiencies. WellCare, ATC, and Molina have implemented all proposed changes; however, BlueChoice and Select have uncorrected deficiencies from the previous EQR.

South Carolina Solutions

South Carolina Solutions' (Solutions) parent company is Community Health Solutions (CHS) of America Inc. The CHS Board of Directors, Executive Committee, and local Executive Director oversee operations. It appears Solutions has sufficient staff to conduct all required services for participants.

The Compliance Officer/Privacy Officer oversees, investigates, and manages all aspects of the Compliance Program and investigates allegations of privacy violations. Staff is provided with compliance and confidentiality training upon hire and annually thereafter. Provider compliance training is provided by the Program Operations Coordinator.

Processes exist for securing and managing protected health information (PHI), and appropriate disaster recovery plans are in place.

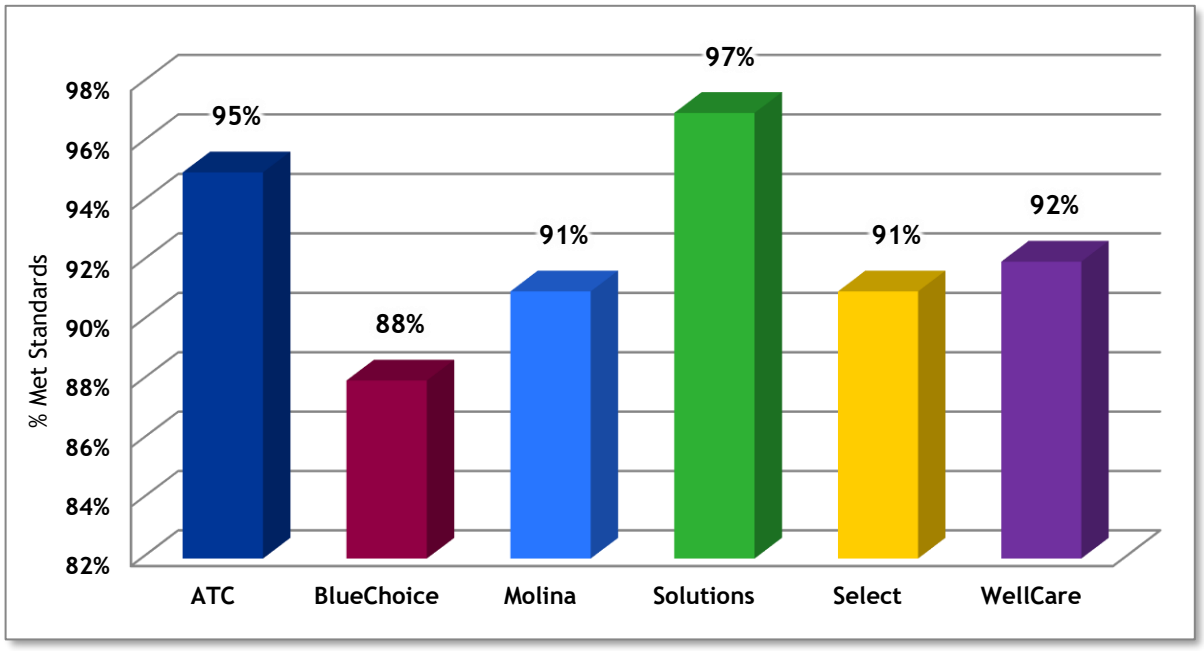
A policy is in place that defines processes for onboarding new providers within the company's physician network. New providers receive orientation and training within thirty days of contracting with the company. The *Provider Manual* is used to educate providers on the Medically Complex Children's Waiver (MCCW) program and contractual obligations.

Solutions submitted its *2018 Strategic Quality Plan*, work plans, committee minutes, and an annual report to demonstrate the program Solutions has in place to improve the care and services provided to members and providers. CCME found no deficiencies in the Quality Improvement section; however, CCME recommendations were made to update the *Strategic Quality Plan*, the work plan, committee minutes, and the committee membership list.

Solutions policies address care coordination processes and frequency of provided services. CCME's review of case management files indicates Care Coordinators and Care Advocates follow policies as outlined. Documentation reflects that provider offices are actively involved in reviewing participant service plans. The files also indicate quarterly visits are consistently completed; however, team conferences are rarely noted.

The following figure illustrates the percentage of "Met" standards achieved by each health plan during the 2017 – 2018 EQRs.

Figure 1: Percentage of Met Standards



B. Overall Scoring

CCME applied a numerical score (points) to each standard's rating within a section to derive the overall score (percentage) for each plan. Using the Centers for Medicare & Medicaid Services (CMS) Protocol, *External Quality Review Protocol for Accessing Compliance with Medicaid Managed Care Regulation*, CCME calculated the overall score based on the following method:

- Points are assigned to each rating ("Met" = 2 points, "Partially Met" = 1 point, “Not Met” = 0 points), excluding "Not Evaluated" and "Not Applicable" ratings from the calculation.
- The total points achieved for each section is calculated by adding the earned points together.
- An average for each section score is derived by dividing the section’s total points (total points achieved) by the total possible points for that section (total number of ratings in that section x 2 points).

- The overall score (percentage) is then calculated by averaging the seven section scores (see *Table 1: Scoring Matrix*).

Table 1: Scoring Matrix

Health Plan	Score
ATC	95%
Blue Choice	88%
Molina	94%
Select	86%
WellCare	94%
SC Solutions	98%

Note. SC Solutions is reviewed based on a different set of standards. The overall score is calculated using the same methodology described above.

C. Coordinated and Integrated Care Organization Annual Review

The review of the Coordinated and Integrated Care Organizations (CICO) focused on four areas: Home and Community Based Services and Behavioral Health Provider Network

Adequacy, Evaluation of Over/Under Utilization, Care Transitions, and Quality Improvement Projects.

Each CICO submitted a Home and Community Based Services (HCBS) and Behavioral Health provider file which CCME evaluated to assess provider adequacy. None of the CICOs met the minimum requirements for an adequate HBCS provider network. ATC's review included a total of 35 active counties out of 46 counties in SC. Results showed 187 out of 245 (76%) required services met the minimum requirement. Molina had the 29 active counties, and 150 services (74%) of 203 had the minimum number of providers required. Select has 39 total active counties and 237 (87%) of the 273 services met the minimum number of required providers. None of the plans met the network requirements for Personal Emergency Response System (PERS) and Telemonitoring. Select met most of the services in each county and only lacked providers in the Adult Day Health, PERS, and Telemonitoring categories.

ATC and Select met the requirements for an adequate network of behavioral health providers. For Molina, all 29 (100%) counties had a choice of at least two behavioral health providers for members when including adjacent counties. For Community Mental Health Center (CMHC) access, 23 of the 29 counties had a CMHC in the primary or adjacent county (79%).

The CICOs are performing care transition functions to minimize unnecessary complications related to care setting transitions. Communication between the CICOs, hospitals and other providers is an issue found with the three CICOs. Untimely notifications by facilities of member admissions and discharges caused untimely follow-ups. Collaboration with the member's primary care physician during the transition process is an issue for Molina and Select.

BACKGROUND

As detailed in the *Executive Summary*, CCME as the EQRO conducts an EQR of each MCO participating in the Medicaid Managed Care Program on behalf of SCDHHS. Federal regulations require that EQRs include three mandatory activities: validation of PIPs, validation of PMs, and an evaluation of compliance with state and federal regulations for each health plan.

Federal regulations also allow states to require optional activities that may include:

- Validating encounter data
- Administering and validating consumer and provider surveys
- Calculating additional PMs
- Conducting PIPs and quality of care studies

After completing the annual review of required EQR activities, CCME submits a detailed technical report to SCDHHS and the health plan. This report describes the data aggregation and analysis and how conclusions are drawn about the quality, timeliness, and access to care furnished by the plans. The report also contains the plan's strengths and weaknesses; recommendations for improvement; and the degree to which the plan addressed the Quality Improvement recommendations made during the prior year's review. Annually, CCME prepares a comprehensive technical report for the State that is a compilation of the individual annual review findings. The comprehensive technical report for contract year 2017 through 2018 contains data for: ATC, BlueChoice, Molina, Select, SC Solutions, and WellCare. The report also includes EQR for the plans participating in the Healthy Connections Prime Program under review during this reporting period.

METHODOLOGY

The process used by CCME for the EQR activities is based on CMS protocols and includes a desk review of documents submitted by each health plan and onsite visits to the plans' offices. After completing the annual review, CCME submits a detailed technical report to SCDHHS and the health plan (covered in the preceding section titled, *Background*). For a health plan not meeting requirements, CCME requires the plan to submit a Quality Improvement Plan for each standard identified as not fully met. CCME also provides technical assistance to each health plan until all deficiencies are corrected.

The following table displays the dates of the EQRs were conducted for each health plan.

Table 2: External Quality Review Dates

Health Plan	EQR Initiated	Onsite Dates	Reports Submitted
Absolute Total Care	December 2017	March 2018	March 2018
BlueChoice	March 2018	May 2018	June 2018
Molina	February 2018	April 2018	May 2018
SC Solutions	May 2018	July 2018	August 2018
Select	September 2017	November 2017	December 2017
WellCare	October 2017	December 2017	January 2018

FINDINGS

The plans were evaluated using the standards developed by CCME and summarized in the tables for each of the sections that follow. CCME scored each standard as fully meeting a standard ("Met"), acceptable but needing improvement ("Partially Met"), failing a standard ("Not Met"), "Not Applicable," or "Not Evaluated." The tables reflect the scores for each standard evaluated in the EQR.

A. Administration

CCME's review of the Administration section of the EQR includes an evaluation of the health plans' policies and procedures, organizational structure and staffing, information systems, compliance, program integrity, and confidentiality. All MCOs have policies and procedures that define business practices, are well-organized, and are consistently reviewed and updated. Staffing and leadership personnel levels appear adequate to ensure the plans can provide all health care products and services required by the *SCDHHS Contract*.

The health plans have comprehensive documents such as policies and procedures, Compliance Plans, and Fraud, Waste, and Abuse (FWA) Plans to address compliance with Program Integrity (PI) requirements. Plans conduct and track new and existing employee annual compliance training. Each plan has a Compliance Committee to monitor, audit, and conduct inquiries and investigations regarding compliance matters. BlueChoice received a "Not Met" score because of noted discrepancies in Compliance Committee membership across the Compliance Committee Charter, the QI Program Description, and the Committee Membership List for the Medicaid Compliance Committee. This is a deficiency identified during the previous EQR. CCME also noted a discrepancy in the

frequency of Compliance Committee meetings. Each plan has processes in place for auditing and investigating suspected FWA.

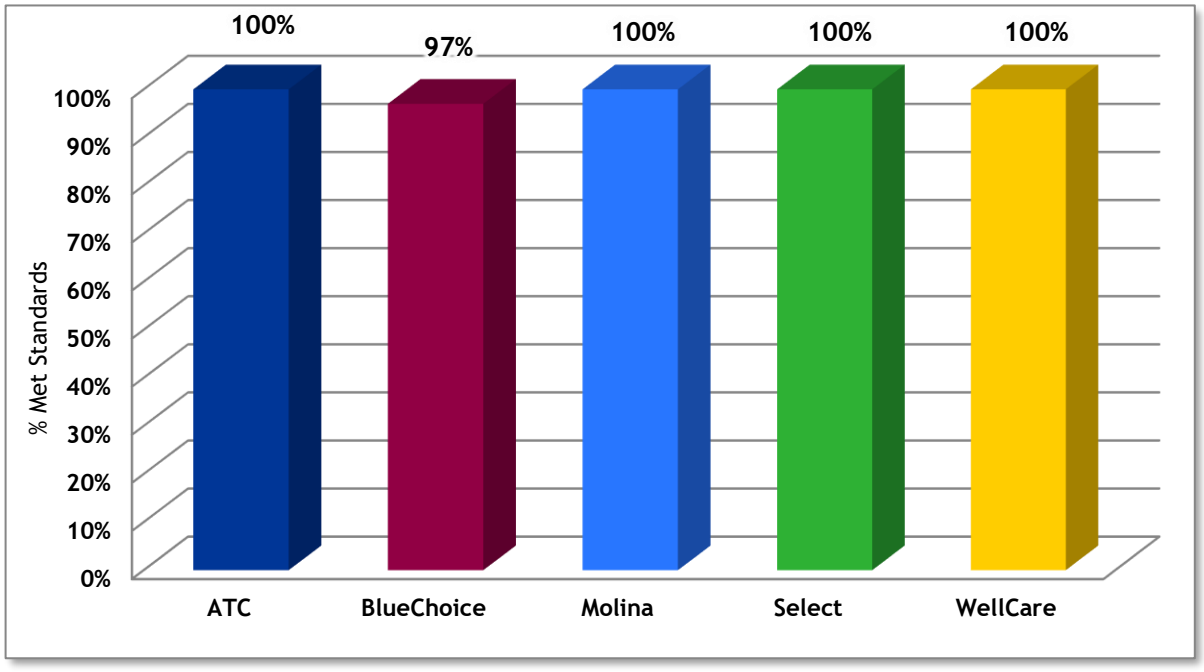
The plans have policies and procedures that address privacy and confidentiality along with uses and disclosures of PHI. Health Insurance Portability and Accountability Act (HIPAA) training is conducted prior to employees receiving access to PHI. Policies are in place for all plans to ensure appropriate release of medical information, including consent.

Information Systems Capabilities Assessment

CCME performs an evaluation of the information systems capabilities for each plan as part of the annual review. The evaluation includes an examination of Information System Capabilities Assessment (ISCA) documents as well as other supporting documents. The aim is to ensure that the plans can manage resources; meet state guidelines for the delivery of health care services; collect health care data securely and accurately; process claims appropriately and in a timely manner; and provide reports about these activities as required by SCDHHS. CCME's review of the ISCA and documents for each of the plans determined all plans have established guidelines for monitoring the timeliness and accuracy of claims processing, and they consistently meet or exceed the standards of the *SCDHHS Contract*. All plans provided comprehensive materials detailing procedures that follow HIPAA standards and practices, including accepting and generating HIPAA-compliant electronic transactions. Each plan's information indicates the necessary systems and processes are in place to collect, report, and process data required by the *SCDHHS Contract* adequately. For system and information security, access management, and disaster recovery/business continuity plan, all plans provided documentation showing they are capable of satisfying requirements and have safe computing practices.

An overview of the "Met" scores for the Administration section is illustrated in *Figure 2: Administration*. ATC, Molina, Select and WellCare achieved "Met" scores for 100% of the standards in the Administration section while BlueChoice achieved "Met" scores for 87% of the standards.

Figure 2: Administration



An overview of the scores for the Administration section is illustrated in *Table 3: Administration Comparative Data*.

Table 3: Administration Comparative Data

Standard	ATC	BlueChoice	Molina	Select	WellCare
General Approach to Policies and Procedures					
The MCO has in place policies and procedures that impact the quality of care provided to members, both directly and indirectly	Met	Met	Met	Met	Met
Organizational Chart / Staffing					
*Administrator (CEO, COO, Executive Director)	Met	Met	Met	Met	Met
Chief Financial Officer (CFO)	Met	Met	Met	Met	Met
*Contract Account Manager	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
Information Systems personnel	Met	Met	Met	Met	Met
Claims and Encounter Manager/ Administrator	Met	Met	Met	Met	Met
Network Management Claims/ Encounter Processing Staff	Met	Met	Met	Met	Met
Utilization Management (Coordinator, Manager, Director)	Met	Met	Met	Met	Met
Pharmacy Director	Met	Met	Met	Met	Met
Utilization Review Staff	Met	Met	Met	Met	Met
*Case Management Staff	Met	Met	Met	Met	Met
*Quality Improvement (Coordinator, Manager, Director)	Met	Met	Met	Met	Met
Quality Assessment and Performance Improvement Staff	Met	Met	Met	Met	Met
*Provider Services Manager	Met	Met	Met	Met	Met
*Provider Services Staff	Met	Met	Met	Met	Met
*Member Services Manager	Met	Met	Met	Met	Met
Member Services Staff	Met	Met	Met	Met	Met
*Medical Director	Met	Met	Met	Met	Met
*Compliance Officer	Met	Met	Met	Met	Met
Program Integrity Coordinator	Met	Met	Met	Met	Met
Compliance /Program Integrity Staff	Met	Met	Met	Met	Met
*Interagency Liaison	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
Legal Staff	Met	Met	Met	Met	Met
Board Certified Psychiatrist	Met	Met	Met	Met	Met
Post-payment Review Staff	Met	Met	Met	Met	Met
Operational relationships of MCO staff are clearly delineated	Met	Met	Met	Met	Met
Operational responsibilities and appropriate minimum education and training requirements are identified for all MCO staff positions	Met	Met	Met	Met	Met
Management Information Systems					
The MCO processes provider claims in an accurate and timely fashion	Met	Met	Met	Met	Met
The MCO is capable of accepting and generating HIPAA compliant electronic transactions	Met	Met	Met	Met	Met
The MCO tracks enrollment and demographic data and links it to the provider base	Met	Met	Met	Met	Met
The MCO management information system is sufficient to support data reporting to the State and internally for MCO quality improvement and utilization monitoring activities	Met	Met	Met	Met	Met
The MCO has policies, procedures and/or processes in place for addressing data security as required by the contract	Met	Met	Met	Met	Met
The MCO has policies, procedures and/or processes in place for addressing system and information security and access management	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
The MCO has a disaster recovery and/or business continuity plan, such plan has been tested, and the testing has been documented	Met	Met	Met	Met	Met
Compliance/Program Integrity					
The MCO has written policies, procedures, and a Compliance Plan that are consistent with state and federal requirements to guard against fraud and abuse	Met	Met	Met	Met	Met
Written policies, training plans, and/or the Compliance Plan includes employee and subcontractor training	Met	Met	Met	Met	Met
The MCO has established a committee charged with oversight of the Compliance program, with clearly delineated responsibilities	Met	Not Met	Met	Met	Met
The MCO has policies and procedures in place that define the processes used to conduct post payment audits and recovery activities for fraud, waste, and abuse activities	Met	Met	Met	Met	Met
The MCO has policies and procedures that define how investigations of all reported incidents are conducted	Met	Met	Met	Met	Met
Confidentiality					
The MCO formulates and acts within written confidentiality policies and procedures that are consistent with state and federal regulations regarding health information privacy	Met	Met	Met	Met	Met

Strengths

- All health plans meet or exceed timeliness requirements for processing claims.

- Each plan has thorough documentation regarding system security practices, processes, and disaster recovery/business continuity.

Weaknesses

- BlueChoice received a "Not Met" score because of noted discrepancies in its Compliance Committee's membership across the Compliance Committee Charter, the QI Program Description, and the Committee Membership List for the Medicaid Compliance Committee. This was a deficiency identified during the previous EQR. CCME also noted a discrepancy in the frequency of Compliance Committee meetings.

Recommendations

- BlueChoice should ensure deficiencies from the previous EQR are addressed.

B. Provider Services

CCME's review of Provider Services includes all policies and procedures; provider agreements; provider training and educational materials; provider network information including access and availability; credentialing and recredentialing; and practice guidelines.

Each plan has established Credentialing Committees with a Medical Director or Chief Medical Officer (CMO) who acts as committee Chairperson. Committee membership includes network providers with voting privileges and each committee has a defined quorum for decision-making. The Credentialing Committee minutes for Select showed there was no quorum for four meetings where decisions were made; this resulted in a "Partially Met" score for the standard. All other plans received "Met" scores for the Credentialing Committee standard.

Each plan has defined credentialing/recredentialing programs for conducting the functions of provider selection, retention, and ongoing monitoring. All the plans were required to make changes to their policies and program materials because of insufficient and/or incorrect information. The common issue included not referencing the need to query the state's *Termination for Cause List*, and this was an issue in the credentialing/recredentialing file review for all the plans as well. In addition, ATC, BlueChoice, and Select files showed inconsistency or no evidence of query of the *Social Security Death Master File* (SSDMF). BlueChoice reported problems obtaining access to the SSDMF that were out of its control; ATC's behavioral health files did not show proof of the query; and Select did not have a process in place at the time of the review. Molina and WellCare had behavioral health files that did not address hospital arrangements.

The adequacy of the provider network is evaluated by each plan through geographic (GEO) access reports and gap analyses. CCME received evidence of appropriate GEO access and network evaluation reports for each plan. Policies define network availability

standards which met contract guidelines for all the plans. For provider accessibility, ATC, Molina and Select had appropriate policies and processes to assess appointment and after-hour access; however, BlueChoice and WellCare received "Partially Met" scores for this standard due to inconsistencies between documents. In addition, BlueChoice measures appointment access through identified questions in the *Adult and Children's CAHPs Survey*, and through analyzing grievances, but not at the provider level.

Each plan maintains a web-based *Provider Directory* that is detailed, user friendly, and addresses contract requirements. Members can contact Member Services for a paper copy of each plan's *Provider Directory*. Molina had to remove outdated language in a policy regarding the Provider Directory, but all other plans received "Met" scores for this standard.

Provider education is conducted for all newly contracted providers and each plan maintains educational resources and reference materials on plan websites.

Preventive and clinical practice guidelines are adopted by all the plans through appropriate processes and committee review. Providers are educated through the *Provider Manual* and other materials, and the guidelines are posted to each plan's website. BlueChoice and Molina received "Partially Met" scores for some of the standards due to outdated materials and/or broken web-links.

All the plans have policies that define acceptable standards for medical record review, educate providers on the guidelines, and assess compliance with the medical record documentation standards. BlueChoice received a "Partially Met" score for one of the standards because of inconsistencies and lack of information between two polices and the review tool.

Provider Access and Availability Study

As a part of the annual review process for all the plans, CCME performed a *Telephonic Provider Access Study* focusing on primary care providers (PCPs) as dictated in *SCDHHS MCO Policy and Procedure Guide*. CCME requested and received a list of network providers and contact information from each of the health plans. From this list, CCME defined a population of PCPs for each plan and selected a statistically relevant sample of providers from each plan's population for the study. CCME attempted to contact these providers to ask a series of questions about the access that plan members have to their PCP.

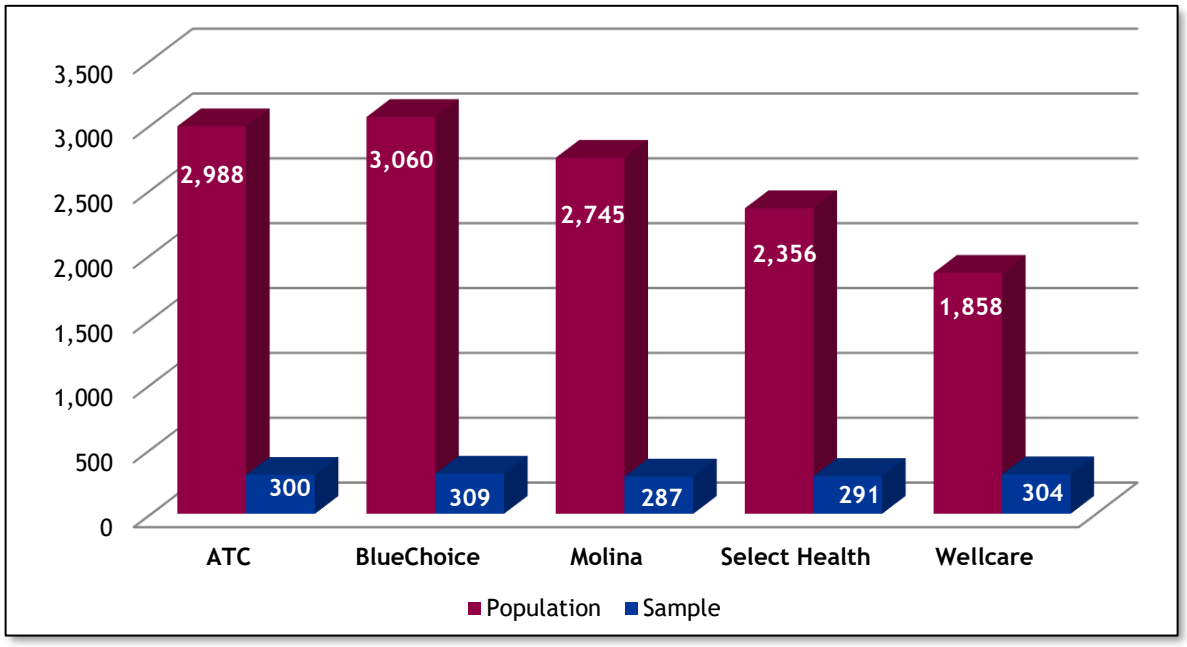
All the plans received a score of "Met" for the standard requiring an improvement to the *Telephonic Provider Access Study* since there was an increase in successfully answered calls for all five plans.

The following charts summarize CCME's survey findings and compare the five plans surveyed during the last review cycle.

Population and Sample Size

From the five MCOs reviewed, CCME identified a total population of 13,007 PCPs. From each plan's population, CCME drew a random sample and selected a total of 1,491 providers as shown in *Figure 3*.

Figure 3: Population and Sample Sizes for Each Plan



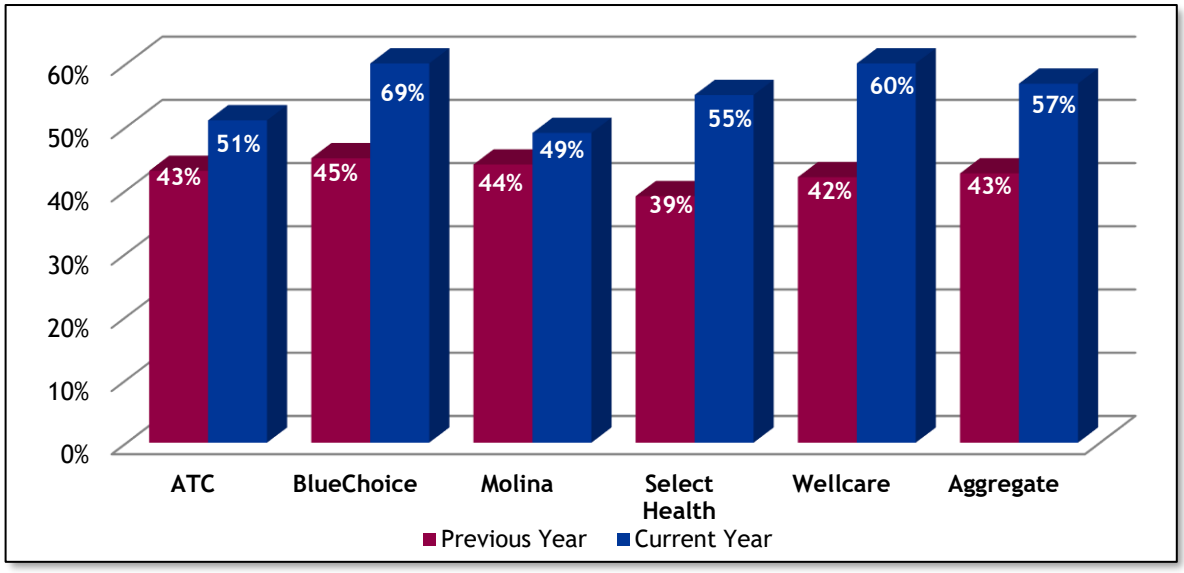
Successfully Answered Calls

CCME used the telephone contact information provided by the plans and called each provider with a series of questions. An adjusted methodology was implemented to calculate the success rate such that the number of calls answered by a voicemail service were omitted from the success rate calculation. The new success rate was calculated as follows:

Success Rate: number of calls answered / (total number of calls - calls answered by a general or personal voicemail service)

In aggregate, the providers answered 57% of the calls successfully (see *Figure 4*), a 14% increase from the previous review cycle rate of 43%. All Plans had an increase in successfully answered calls. All Plans except Molina had a statistically significant increase ($P<.05$).

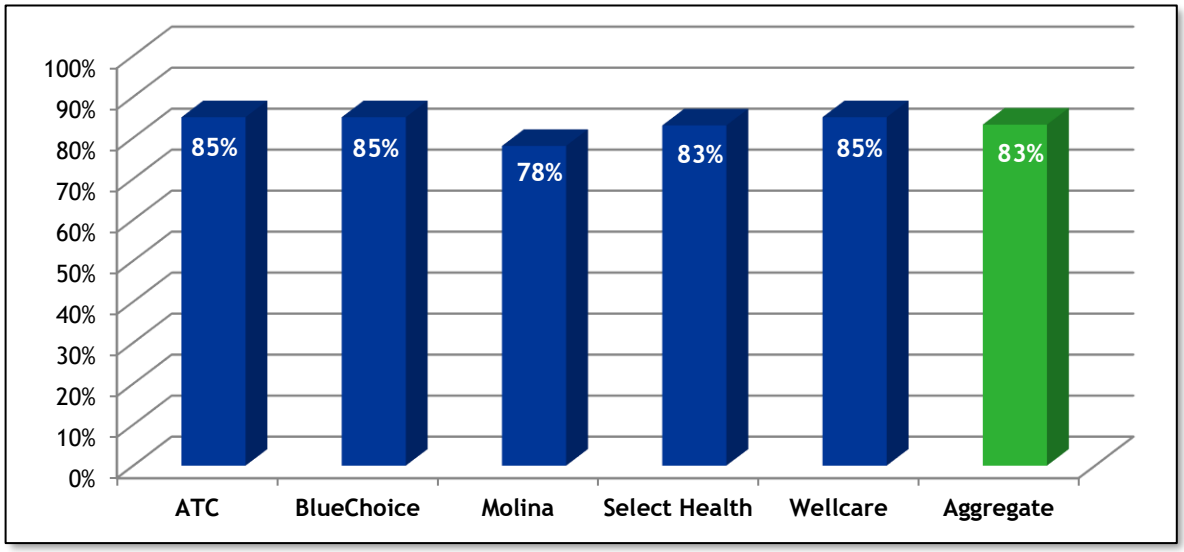
Figure 4: Percentage of Successfully Answered Calls



Currently Accepting the Plan

Of the calls successfully answered, 83% responded that the provider accepts the respective health plan. This is a 1% increase from last year. In the aggregate, approximately 17% of the providers reported they do not accept the plan identified. *Figure 5* displays the percentage of providers that indicated they accept the plan.

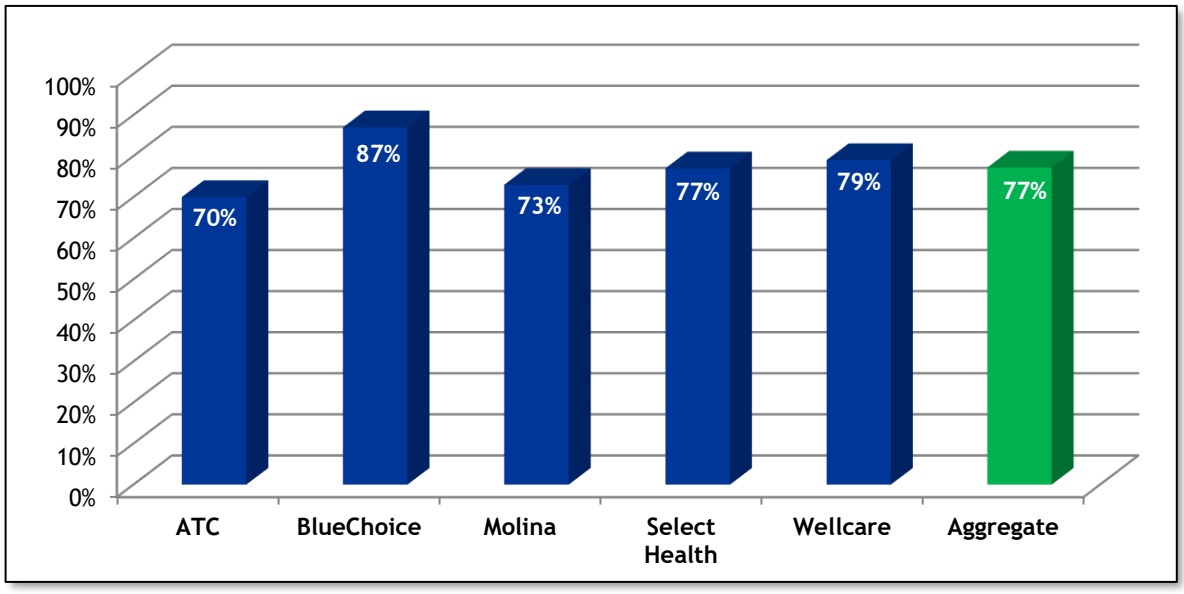
Figure 5: Percentage of Providers Accepting the Plan



Accepting Medicaid Patients

Of the providers accepting the plan, 77% responded that they are accepting new Medicaid patients (see *Figure 6*). This is a 10% increase from the previous review cycle. The results range from ATC at 70% to BlueChoice at 87%.

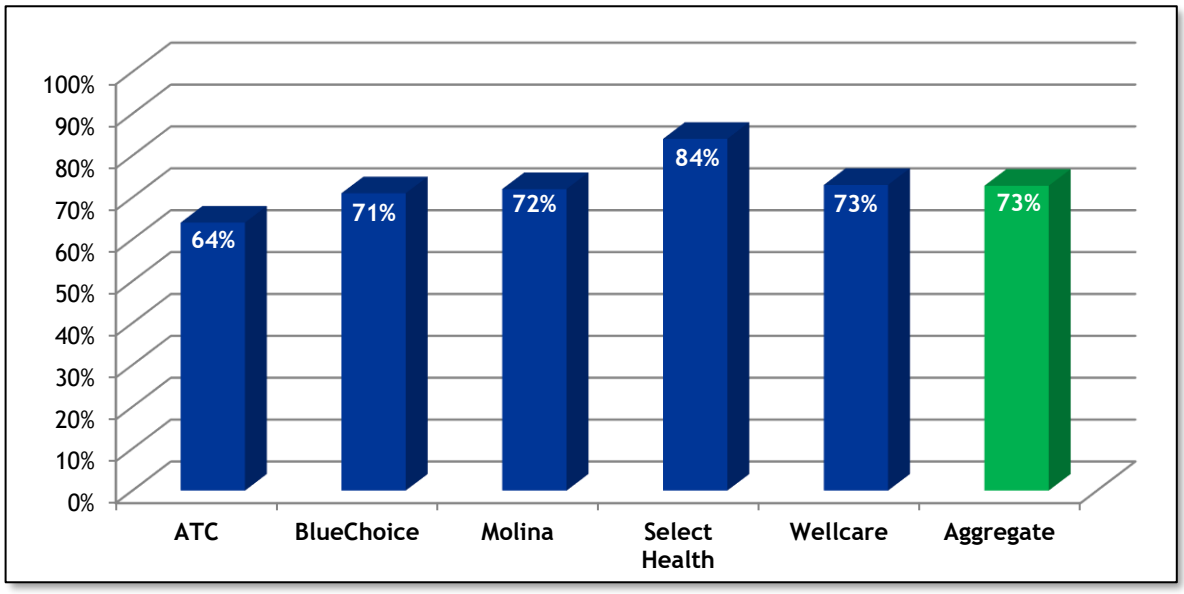
Figure 6: Percentage of Providers Accepting Medicaid Patients



Next Available Appointment

Of those accepting new Medicaid patients, when CCME asked for the next non-urgent, appointment available for the provider, 73% of all providers gave an appointment time that meets the state timeframe requirements for a routine appointment (see *Figure 7*). This is a 5% increase from the prior reporting period. Select had the highest rate of 84% in this category, whereas ATC had the lowest rate at 64%.

Figure 7: Percentage of Providers for which the Next Available Appointment Met Contract Requirements

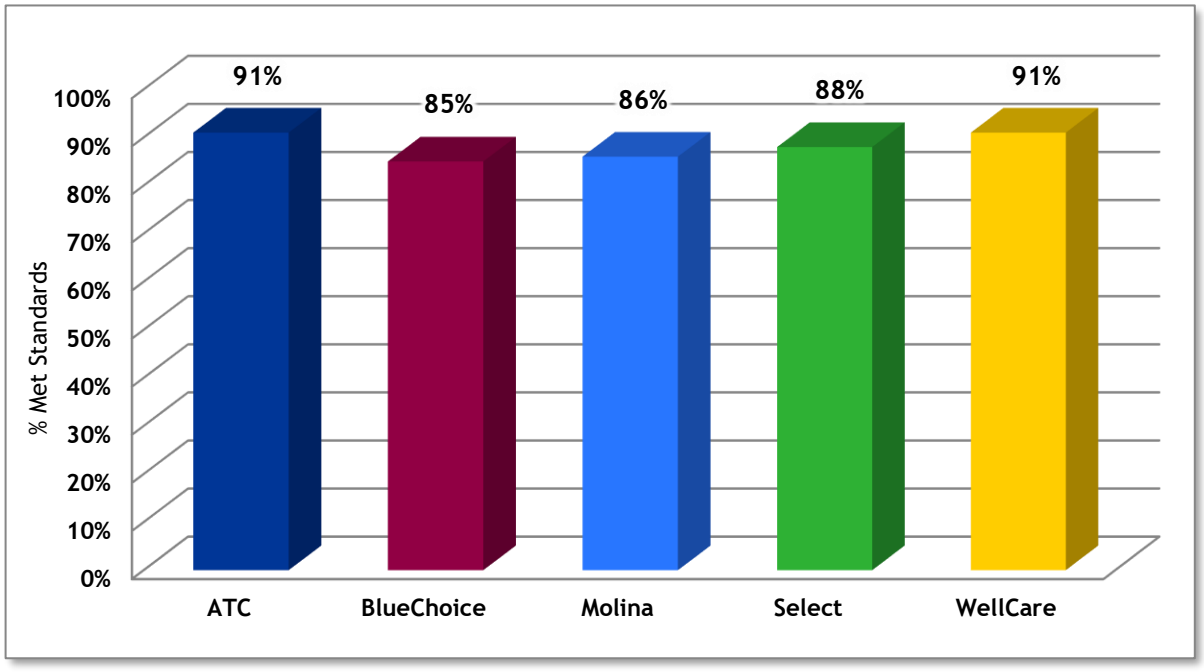


Summary of Study Findings

For all five plans, overall access to providers improved from the previous cycle, as indicated by the increase in the percentage of successfully answered calls in the *Telephonic Provider Access Study*. The revised methodology allowed for a higher success rate since voicemail answering services were omitted from the success rate calculation. The percentage of providers that are currently accepting the plan (83%) is a slight increase from last year. The study revealed a 10% increase in the percentage of providers that accept Medicaid patients and a 5% increase in the percentage of providers who can offer an appointment within state contract requirements compared to last year. All plans met the standard for improvement from the previous *Telephonic Provider Access Study*'s results.

The percentages of "Met" scores for the Provider Services section of the review are illustrated in *Figure 8, Provider Services*.

Figure 8: Provider Services



An overview of the scores for the Provider Services section is illustrated in *Table 4: Provider Services Comparative Data*.

Table 4: Provider Services Comparative Data

Standard	ATC	BlueChoice	Molina	Select	WellCare
Credentialing and Recredentialing					
The MCO formulates and acts within policies and procedures related to the credentialing and recredentialing of health care providers in a manner consistent with contractual requirements	Partially Met	Partially Met	Met	Partially Met	Partially Met
Decisions regarding credentialing and recredentialing are made by a committee meeting at specified intervals and including peers of the applicant. Such decisions, if delegated, may be overridden by the MCO	Met	Met	Met	Partially Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
The credentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Met	Met	Met	Met
Verification of information on the applicant, including: Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met
Valid DEA certificate and/or CDS certificate	Met	Met	Met	Met	Met
Professional education and training, or board certification if claimed by the applicant	Met	Met	Met	Met	Met
Work history	Met	Met	Met	Met	Met
Malpractice claims history	Met	Met	Met	Met	Met
Formal application with attestation statement delineating any physical or mental health problem affecting ability to provide health care, any history of chemical dependency/ substance abuse, prior loss of license, prior felony convictions, loss or limitation of practice privileges or disciplinary action, the accuracy and completeness of the application	Met	Met	Met	Met	Met
Query of the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met
No debarred, suspended, or excluded from Federal procurement activities: Query of System for Award Management (SAM)	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
Query for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met	Met
Query of the State Excluded Provider's Report and the SC Providers Terminated for Cause list	Not Met	Not Met	Partially Met	Partially Met	Partially Met
Query for Medicare and/or Medicaid sanctions (5 years); OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met	Met
Query of Social Security Administration's Death Master File (SSDMF)	Partially Met	Partially Met	Met	Not Met	Met
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met
In good standing at the hospital designated by the provider as the primary admitting facility	Met	Met	Partially Met	Met	Partially Met
Clinical Laboratory Improvement Amendment (CLIA) Certificate (or certificate of waiver) for providers billing laboratory procedures	Met	Met	Met	Met	Met
Ownership Disclosure form	Met	Met	Met	Met	Met
Receipt of all elements prior to the credentialing decision, with no element older than 180 days	Met	Met	Met	Met	Met
The recredentialing process includes all elements required by the contract and by the MCO's internal policies	Met	Met	Met	Met	Met
Recredentialing conducted at least every 36 months	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
Verification of information on the applicant, including Current valid license to practice in each state where the practitioner will treat members	Met	Met	Met	Met	Met
Valid DEA certificate and/or CDS certificate	Met	Met	Met	Met	Met
Board certification if claimed by the applicant	Met	Met	Met	Met	Met
Malpractice claims since the previous credentialing event	Met	Met	Met	Met	Met
Practitioner attestation statement	Met	Met	Met	Met	Met
Requery the National Practitioner Data Bank (NPDB)	Met	Met	Met	Met	Met
Requery of System for Award Management (SAM)	Met	Met	Met	Met	Met
Requery for state sanctions and/or license or DEA limitations (State Board of Examiners for the specific discipline)	Met	Met	Met	Met	Met
Requery of the State Excluded Provider's Report and the SC Providers Terminated for Cause list	Not Met	Not Met	Partially Met	Partially Met	Partially Met
Requery for Medicare and/or Medicaid sanctions since the previous credentialing event; OIG List of Excluded Individuals and Entities (LEIE)	Met	Met	Met	Met	Met
Query of the Social Security Administration's Death Master File (SSDMF)	Partially Met	Partially Met	Met	Not Met	Met
Query of the National Plan and Provider Enumeration System (NPPES)	Met	Met	Met	Met	Met
In good standing at the hospitals designated by the provider as the primary admitting facility	Met	Met	Partially Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
Clinical Laboratory Improvement Amendment (CLIA) Certificate for providers billing laboratory procedures	Met	Met	Met	Met	Met
Ownership Disclosure form	Met	Met	Met	Met	Met
Review of practitioner profiling activities	Met	Met	Met	Met	Met
The MCO formulates and acts within written policies and procedures for suspending or terminating a practitioner's affiliation with the MCO for serious quality of care or service issues	Met	Met	Met	Partially Met	Met
Organizational providers with which the MCO contracts are accredited and/or licensed by appropriate authorities	Not Met	Partially Met	Partially Met	Partially Met	Partially Met
Monthly provider monitoring is conducted by the MCO to ensure providers are not prohibited from receiving Federal funds	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met
Adequacy of the Provider Network					
The MCO maintains a network of providers that is sufficient to meet the health care needs of members and is consistent with contract requirements Members have a primary care physician located within a 30-mile radius of their residence	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
Members have access to specialty consultation from a network provider located within reasonable traveling distance of their homes. If a network specialist is not available, the member may utilize an out-of-network specialist with no benefit penalty	Met	Met	Met	Met	Met
The sufficiency of the provider network in meeting membership demand is formally assessed at least bi-annually	Met	Met	Met	Met	Met
Providers are available who can serve members with special needs such as hearing or vision impairment, foreign language/cultural requirements, and complex medical needs	Met	Met	Met	Met	Met
The MCO demonstrates significant efforts to increase the provider network when it is identified as not meeting membership demand	Met	Met	Met	Met	Met
The MCO maintains a provider directory that includes all requirements outlined in the contract.	Met	Met	Partially Met	Met	Met
The MCO formulates and insures that practitioners act within written policies and procedures that define acceptable access to practitioners and that are consistent with contract requirements	Met	Partially Met	Met	Met	Partially Met
The Telephonic Provider Access Study conducted by CCME shows improvement from the previous study's results	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
Provider Education					
The MCO formulates and acts within policies and procedures related to initial education of providers	Met	Met	Met	Met	Met
Initial provider education includes MCO structure and health care programs	Met	Met	Met	Met	Met
Billing and reimbursement practices	Met	Met	Met	Met	Met
Member benefits, including covered services, excluded services, and services provided under fee-for-service payment by SCDHHS	Met	Met	Met	Met	Met
Procedure for referral to a specialist	Met	Met	Met	Met	Met
Accessibility standards, including 24/7 access	Met	Met	Met	Met	Met
Recommended standards of care	Met	Met	Met	Met	Met
Medical record handling, availability, retention and confidentiality	Met	Met	Met	Met	Met
Provider and member grievance and appeal procedures	Met	Met	Met	Met	Met
Pharmacy policies and procedures necessary for making informed prescription choices	Met	Met	Met	Met	Met
Reassignment of a member to another PCP	Met	Met	Met	Met	Met
Medical record documentation requirements	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
The MCO provides ongoing education to providers regarding changes and/or additions to its programs, practices, member benefits, standards, policies and procedures	Met	Met	Met	Met	Met
Primary and Secondary Preventive Health Guidelines					
The MCO develops preventive health guidelines for the care of its members that are consistent with national standards and covered benefits and that are periodically reviewed and/or updated	Met	Met	Met	Met	Met
The MCO communicates the preventive health guidelines and the expectation that they will be followed for MCO members to providers	Met	Partially Met	Partially Met	Met	Met
The preventive health guidelines include, at a minimum, the following if relevant to member demographics Well child care at specified intervals, including EPSDTs at State-mandated intervals	Met	Met	Met	Met	Met
Recommended childhood immunizations	Met	Met	Met	Met	Met
Pregnancy care	Met	Met	Met	Met	Met
Adult screening recommendations at specified intervals	Met	Met	Met	Met	Met
Elderly screening recommendations at specified intervals	Met	Met	Met	Met	Met
Recommendations specific to member high-risk groups	Met	Met	Met	Met	Met
Behavioral Health Services	Met	Partially Met	Met	Met	Met
Clinical Practice Guidelines for Disease and Chronic Illness Management					

Standard	ATC	BlueChoice	Molina	Select	WellCare
The MCO develops clinical practice guidelines for disease, chronic illness management, and behavioral health services of its members that are consistent with national or professional standards and covered benefits, are periodically reviewed and/or updated and are developed in conjunction with pertinent network specialists	Met	Met	Met	Met	Met
The MCO communicates the clinical practice guidelines for disease, chronic illness management, and behavioral health services and the expectation that they will be followed for MCO members to providers	Met	Partially Met	Partially Met	Met	Met
Continuity of Care					
The MCO monitors continuity and coordination of care between the PCPs and other providers	Met	Met	Met	Met	Met
Practitioner Medical Records					
The MCO formulates policies and procedures outlining standards for acceptable documentation in the member medical records maintained by primary care physicians	Met	Met	Met	Met	Met
Standards for acceptable documentation in member medical records are consistent with contract requirements	Met	Partially Met	Met	Met	Met
The MCO monitors compliance with medical record documentation standards through periodic medical record audit and addresses any deficiencies with the providers	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
Accessibility to member medical records by the MCO for the purposes of quality improvement, utilization management, and/or other studies is contractually assured for a period of 5 years following expiration of the contract	Met	Met	Met	Met	Met

Strengths

- For the Telephonic Provider Access Study conducted by CCME, all five plans showed improvement from the previous year's results.
- Plan websites contain valuable resources and educational information for providers.

Weaknesses

- All the plans were required to make changes to their policies and program materials because of insufficient or incorrect information. A common issue included not referencing the need to query the *Termination for Cause List*.
- All the plans had issues with the credentialing/recredentialing files not containing evidence of querying the *Termination for Cause List*.
- ATC, BlueChoice, and Select credentialing/recredentialing files showed inconsistency or no evidence of querying the *Social Security Death Master File* (SSDMF).
- Molina and WellCare had behavioral health credentialing/recredentialing files that did not address hospital arrangements.
- A review of Select's Credentialing Committee minutes showed there was no quorum for four meetings where decisions were made.
- For provider accessibility, BlueChoice and WellCare received "Partially Met" scores due to inconsistencies between documents, and BlueChoice does not measure appointment access at the provider level.
- Molina had to remove outdated policy language regarding the *Provider Directory*.
- BlueChoice and Molina received "Partially Met" scores for some of the preventive/clinical practice guidelines standards due to outdated materials and broken web-links.
- BlueChoice received a "Partially Met" score for one of the medical record review standards because of inconsistencies/lack of information between two polices and the review tool.

Recommendations

- For credentialing/recredentialing, plans need to query the *Termination for Cause List* and the SSDMF, and ensure the files contain evidence of the queries.
- Update outdated materials and broken weblinks for preventive/clinical practice guidelines.
- Correct outdated or incorrect language in documents and ensure the presence of a quorum at all Credentialing Committee meetings where decisions are made.

C. Member Services

CCME's Member Services review includes member rights and responsibilities; member education on the health plan and preventive/chronic disease management; processes for member disenrollment; processes for receiving and responding to member grievances; and annual member satisfaction surveys.

Each of the MCOs has policies defining member rights and responsibilities as well as processes to ensure members understand the rights to which they are entitled. Members are provided education on member rights in various ways, including Member Handbooks, plan websites, and member newsletters. Member rights are included in Provider Manuals and providers are educated about the importance of compliance with member rights.

The health plans have established processes for providing new member education. Common issues for each plan's member materials include errors in benefit information such as covered/excluded services and service limitations (ATC, Molina) and errors, omissions, and discrepancies in copayment information (ATC, BlueChoice, Molina). In addition, BlueChoice had errors in documentation of information about member disenrollment, an incorrect email address for the Member Services Department, and inaccurate links to obtain information about providers and Advance Directives. The plans have sufficient processes in place to verify member materials are written in appropriate language and at an appropriate reading level.

Member Services call centers are available to members via toll-free telephone numbers and staffed during the contractually required business hours. Outside of normal business hours, members can speak with staff at a 24-hour nurse advice line or leave a confidential voicemail message for Member Services staff. Of note, Select staffs the Member Services call center from 8:00 am to 9:00 pm, Monday through Friday, from 8:00 am to 6:00 pm on weekends, and provides holiday coverage.

All the MCOs track and monitor member compliance with recommended Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and immunizations. As required by the *SCDHHS Contract, Section 4.2.10.1*, most of the plans have policies that define processes for tracking eligible member use of EPSDT services and recommended

immunizations; however, Molina confirmed it has not developed such a policy. The plans use various outreach methods to encourage members to obtain the recommended EPSDT services and immunizations, including mailed letters and postcards, live calls, automated calls, etc. In addition, various educational materials are provided to members-at-large and community forums are hosted to provide educational opportunities to members and others.

Policies are in place to guide health plan staff in conducting grievance receipt and processing. Information on grievances is included in Member Handbooks, Provider Manuals, and on health plan websites, including definitions of various grievance terminology. CCME recommends that BlueChoice and WellCare update definitions to reflect the language in the most current SCDHHS Contract and Federal Regulation. Three of the five MCOs received deficiencies for documentation of procedures for filing and handling grievances. Four of the MCOs received deficiencies for documentation related to grievance resolution timeframes. CCME's review of grievance files revealed common and/or significant issues, including:

- Failure to send an acknowledgement letter and acknowledgement letters sent outside of the required timeframe (BlueChoice, Select, WellCare)
- Lack of, or incomplete, documentation of the grievance investigation (ATC, BlueChoice, Molina)
- Incorrect identification of the grievance type in resolution letters (ATC)
- Resolution letters not addressing all findings of the grievance investigation (BlueChoice)
- Failure to send a resolution letter and resolution letters sent outside of the required timeframe (Select, WellCare)
- Resolution letters containing abbreviations, terminology, or language that members might not understand (ATC, BlueChoice)
- Inappropriate resolution that the member is financially responsible for an emergency room visit (Select)
- Failure to refer potential quality of care issues for investigation (BlueChoice)

During discussion of the issues identified in the grievance files, ATC indicated it had already identified the issues and that action was taken to correct the issues, including counseling, retraining staff, and removing one staff member from grievance processing duties.

Two of the MCOs—BlueChoice and Select—had deficiencies in the grievance area of the review which were identified during the previous EQR, resulting in scores of "Not Met" for the applicable standards.

All the MCOs have implemented processes to monitor and track grievances to identify and address trends. Grievance data are reported to other departments and to appropriate committees.

Member Satisfaction

As required by the contract, all five health plans conducted Member Satisfaction Surveys. As part of the annual EQR, CCME conducted a validation review of the Member Satisfaction Surveys using the protocol developed by CMS entitled, *EQR Protocol 5: Validation and Implementation of Surveys – A Voluntary Protocol for External Quality Review*. The role of the protocol is to provide the State with assurance that the results of the surveys are reliable and valid. The validation protocol is decomposed into seven activities:

- Review survey purpose(s), objective(s), and intended use
- Assess the reliability and validity of the survey instrument
- Review the sampling plan
- Assess the adequacy of the response rate
- Review survey implementation
- Review survey data analysis and findings/conclusions
- Document evaluation of the survey

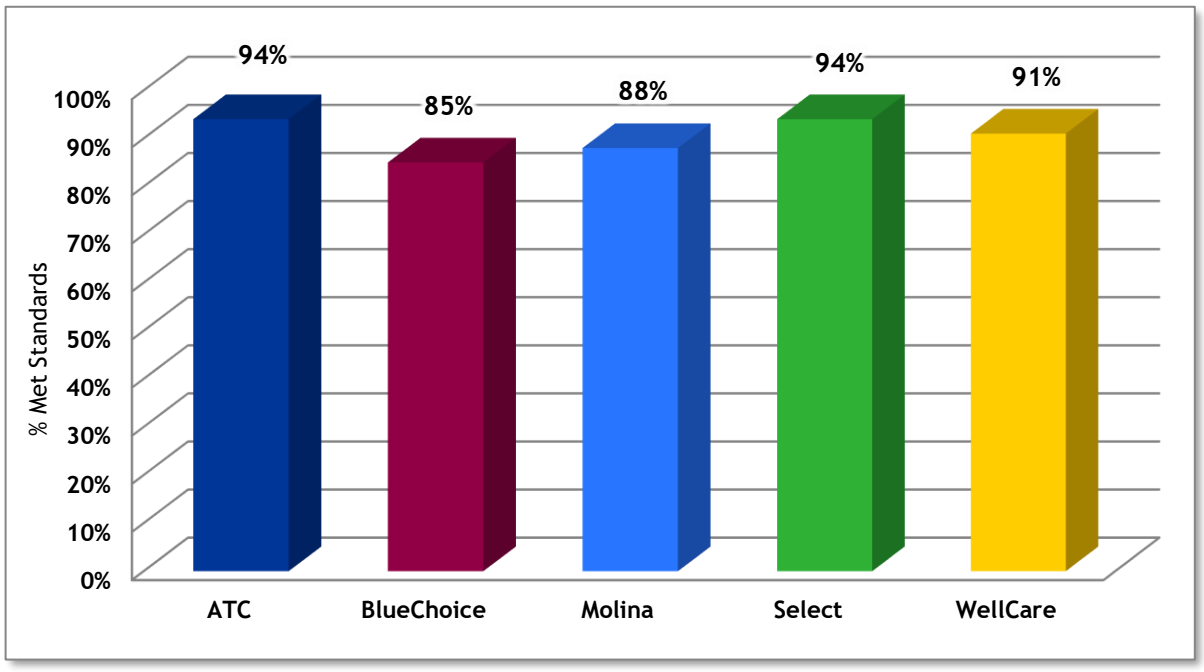
All five plans use a National Committee for Quality Assurance (NCQA)-certified vendor to conduct Member Satisfaction Surveys. All the plans response rates were below the NCQA target response rate of 40.0% for both the adult and child surveys. For Select, the survey response rates showed a slight increase from the previous year. For WellCare, the survey response rates decreased from the previous year's survey by 7% for the adult survey and over 5% for the child survey. WellCare's rates have continued to decline from 2015 to 2016 to 2017.

Three of the plans met the target number of valid surveys (n=411) set by NCQA; however, the adult member respondents for Select and both adult and child member respondents for WellCare do not meet the minimum of 411 responses. The low response rates across plans can lead to response bias and results that do not represent the entire member population. CCME recommends the plans solicit the help of the survey vendors to increase the response rates for next year's survey, incorporate reminders into the Call Center script, use the website to announce the survey, and use maximum allowed over-sampling.

Figure 9: Member Services, illustrates the percentage of "Met" scores in the Member Services portion of the review for each plan. Of the five plans, only one (Select) exhibits an increase in the percentage of "Met" scores. The largest decrease is noted for

BlueChoice (from 94.6% to 85%), and the smallest decrease is noted for ATC (from 95%to 94%).

Figure 9: Member Services



A comparison of the plans' scores for the standards in the Member Services section is illustrated in *Table 5: Member Services Comparative Data*

Table 5: Member Services Comparative Data

Standard	ATC	BlueChoice	Molina	Select	WellCare
Member Rights and Responsibilities					
The MCO formulates and implements policies guaranteeing member rights and responsibilities and procedures for informing members of these rights and responsibilities	Met	Met	Met	Met	Met
All Member rights included	Met	Met	Met	Met	Met
Member MCO Program Education					

Standard	ATC	BlueChoice	Molina	Select	WellCare
Members are informed in writing within 14 calendar days from MCO's receipt of enrollment data from DHHS of all benefits and MCO information including:	Partially Met	Partially Met	Partially Met	Met	Met
Members are informed promptly in writing of changes in benefits on an ongoing basis, including changes to the provider network	Met	Met	Met	Met	Met
Member program education materials are written in a clear and understandable manner and meet contract requirements	Met	Met	Met	Partially Met	Met
The MCO maintains and informs members of how to access a toll-free vehicle for 24-hour member access to coverage information from the MCO, including the availability of free oral translation services for all languages	Met	Met	Met	Met	Met
Member grievances, denials, and appeals are reviewed to identify potential member misunderstanding of the MCO program, with reeducation occurring as needed	Met	Met	Met	Met	Met
Member Disenrollment					
Member disenrollment is conducted in a manner consistent with contract requirements	Met	Met	Met	Met	Met
Preventive Health and Chronic Disease Management Education					
The MCO enables each member to choose a PCP upon enrollment and provides assistance as needed	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
The MCO informs members about the preventive health and chronic disease management services that are available to them and encourages members to utilize these benefits	Met	Met	Met	Met	Met
The MCO identifies pregnant members; provides educational information related to pregnancy, prepared childbirth, and parenting; and tracks the participation of pregnant members in their recommended care	Met	Met	Met	Met	Met
The MCO tracks children eligible for recommended EPSDTs and immunizations and encourages members to utilize these benefits	Met	Met	Partially Met	Met	Met
The MCO provides educational opportunities to members regarding health risk factors and wellness promotion	Met	Met	Met	Met	Met
Member Satisfaction Survey					
The MCO conducts a formal annual assessment of member satisfaction with MCO benefits and services. Such assessment includes, but is not limited to	Met	Met	Met	Met	Met
Statistically sound methodology, including probability sampling to ensure that it is representative of the total membership	Met	Met	Met	Met	Met
The availability and accessibility of health care practitioners and services	Met	Met	Met	Met	Met
The quality of health care received from MCO providers	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
The scope of benefits and services	Met	Met	Met	Met	Met
Claim processing procedures	Met	Met	Met	Met	Met
Adverse decisions regarding MCO claim decisions	Met	Met	Met	Met	Met
The MCO analyzes data obtained from the member satisfaction survey to identify quality problems	Met	Met	Met	Met	Met
The MCO implements significant measures to address quality problems identified through the member satisfaction survey	Met	Met	Met	Met	Met
The MCO reports the results of the member satisfaction survey to providers	Met	Met	Met	Met	Met
The MCO reports to the Quality Improvement Committee on the results of the member satisfaction survey and the impact of measures taken to address those quality problems that were identified	Met	Met	Met	Met	Met
Grievances					
The MCO formulates reasonable policies and procedures for registering and responding to member grievances in a manner consistent with contract requirements, including, but not limited to	Met	Met	Met	Met	Met
Definition of a grievance and who may file a grievance	Met	Met	Partially Met	Met	Met
The procedure for filing and handling a grievance	Partially Met	Not Met	Met	Met	Partially Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
Timeliness guidelines for resolution of the grievance as specified in the contract	Partially Met	Partially Met	Partially Met	Met	Partially Met
Review of all grievances related to the delivery of medical care by the Medical Director or a physician designee as part of the resolution process	Met	Met	Met	Met	Met
Maintenance of a log for oral grievances and retention of this log and written records of disposition for the period specified in the contract	Met	Partially Met	Met	Met	Met
The MCO applies the grievance policy and procedure as formulated	Met	Partially Met	Met	Not Met	Partially Met
Grievances are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met
Grievances are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met	Met

Strengths

- Plans document member rights and provide education to members and providers about member rights.
- Member educational materials use appropriate language for ease of understanding.
- Websites provide a wealth of information for members to learn about their health plans and benefits.
- All plans have processes to encourage members to participate in recommended preventive health/wellness services.

Weaknesses

- Documentation of member benefits, exclusions, limitations, and copayment information contains errors (ATC, BlueChoice, Molina).
- Molina does not have a policy defining processes and requirements for the EPSDT Program as required by the *SCDHHS Contract, Section 4.2.10.1*.
- Response rates for Member Satisfaction Surveys are below the NCQA target response rate of 40.0% for both the adult and child surveys, and WellCare's survey response rates have continued to decline each year from 2015 to 2017.
- The number of respondents for Select's adult Member Satisfaction Survey and for WellCare's adult and child Member Satisfaction Surveys do not meet the target of 411 valid surveys established by NCQA.
- Issues related to documentation of grievances filing and handling processes include:
  - Grievance terminology defined without using the most current terminology from the SCDHHS Contract and Federal Regulation (BlueChoice, WellCare)
  - Errors in documentation of who may file a grievance and grievance filing processes and requirements (ATC, BlueChoice, Molina, WellCare)
  - Errors in documentation of grievance resolution timeframes (ATC, BlueChoice, Molina, WellCare)
  - Inconsistencies in documentation of retention requirements for grievance records (BlueChoice)
- Review of grievance files revealed the following:
  - Failure to send an acknowledgement letter and acknowledgement letters sent outside of the required timeframe (BlueChoice, Select, WellCare)
  - Lack of, or incomplete, documentation of the grievance investigation (ATC, BlueChoice, Molina)
  - Incorrect identification of the grievance type in resolution letters (ATC)
  - Resolution letters do not address all findings of the grievance investigation (BlueChoice)
  - Failure to send a resolution letter and resolution letters sent outside of the required timeframe (Select, WellCare)
  - Resolution letters contain abbreviations, terminology, or language that members might not understand (ATC, BlueChoice)
  - Inappropriate resolution that the member is financially responsible for an emergency room visit (Select)

- Failure to refer potential quality of care issues for investigation (BlueChoice)

Recommendations

- Plans should review and revise member educational materials so that documentation of member benefits, exclusions, limitations, and/or copayment information is complete and correct.
- Molina should ensure a policy defining processes and requirements for its EPSDT program is developed as contractually required.
- Plans should employ interventions such as soliciting help from the survey vendors, incorporating reminders into Call Center scripts, using websites to announce surveys, and using maximum allowed over-sampling for surveys to increase response rates and the number of valid Member Satisfaction Surveys.
- The plans should review and revise all documentation of grievance processes and requirements to reflect complete and correct information.
- The plans should ensure grievance reviewers comply with all requirements for grievance receipt, resolution, and notification of resolution; correctly identify grievance types and use appropriate language in member grievance letters; and refer potential quality of care issues for investigation per policy.

D. Quality Improvement

All the plans have program descriptions and policies as evidence that the programs are designed to provide the structure and key processes for ongoing improvements of care and services available to members and providers. The Board of Directors for each plan has delegated the authority and responsibility for its Quality Improvement (QI) programs. The committee minutes reflect that each quality committee meets regularly, and minutes of the committees' decisions were well-documented.

Performance Measure Validation

Health plans are required to have an ongoing program of Performance Improvement Projects (PIPs) and to report plan performance using HEDIS® measures applicable to the Medicaid population. To evaluate the accuracy of the Performance Measures (PMs) reported, CCME uses the *CMS Protocol, Validation of Performance Measures*. This validation protocol balances the subjective and objective parts of the review, supports a review that is fair to the plans, and provides the State information about how each plan is operating.

All five MCOs were fully compliant. All plans are using a HEDIS® certified vendor or software to collect and calculate the measures. Plan rates for the most recent review year are reported in *Table 6, HEDIS® Performance Measure Data*. The statewide average

is calculated as the average of the plan rates and shown in the last column of the following table.

Table 6: HEDIS® Performance Measure Data for MY 2016

Measure/Data Element	ATC	BlueChoice	Molina	Select	WellCare	Statewide Average
Effectiveness of Care: Prevention and Screening						
Adult BMI Assessment (aba)	87.35%	83.06%	84.79%	86.31%	78.83%	**84.07%**
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (wcc)						
BMI Percentile	68.75%	73.38%	62.47%	71.53%	72.45%	**69.72%**
Counseling for Nutrition	56.01%	60.88%	49.23%	59.03%	55.32%	**56.09%**
Counseling for Physical Activity	44.71%	51.85%	43.27%	56.25%	43.98%	**48.01%**
Childhood Immunization Status (cis)						
DTaP	78.61%	75.46%	65.56%	75.23%	71.53%	**73.28%**
IPV	91.35%	88.89%	81.68%	88.19%	87.04%	**87.43%**
MMR	91.59%	93.06%	86.31%	90.05%	88.89%	**89.98%**
HiB	86.06%	83.33%	75.28%	84.26%	82.41%	**82.27%**
Hepatitis B	93.03%	86.11%	81.24%	85.42%	86.34%	**86.43%**
VZV	92.55%	91.44%	86.75%	90.05%	88.66%	**89.89%**
Pneumococcal Conjugate	81.97%	79.17%	68.21%	78.94%	74.77%	**76.61%**
Hepatitis A	86.78%	87.27%	82.12%	88.66%	84.26%	**85.82%**
Rotavirus	73.80%	74.07%	64.90%	78.24%	68.52%	**71.91%**
Influenza	43.51%	46.30%	32.23%	42.82%	31.48%	**39.27%**
Combination #2	76.68%	68.98%	60.71%	70.14%	67.13%	**68.73%**
Combination #3	75.48%	66.90%	57.84%	68.29%	64.81%	**66.66%**
Combination #4	72.60%	65.05%	56.73%	67.59%	62.27%	**64.85%**
Combination #5	64.18%	57.87%	50.55%	63.19%	53.70%	**57.90%**
Combination #6	38.70%	37.27%	23.40%	38.19%	26.62%	**32.84%**
Combination #7	62.98%	56.48%	50.11%	62.50%	51.62%	**56.74%**
Combination #8	38.22%	37.04%	23.40%	38.19%	25.93%	**32.56%**
Combination #9	34.38%	34.03%	21.19%	36.34%	23.38%	**29.86%**
Combination #10	33.89%	33.80%	21.19%	36.34%	22.69%	**29.58%**
Immunizations for Adolescents (ima)						

Measure/Data Element	ATC	BlueChoice	Molina	Select	WellCare	Statewide Average
Meningococcal	69.23%	62.04%	69.09%	74.54%	66.67%	**68.31%**
Tdap/Td	83.89%	80.32%	86.98%	88.43%	82.18%	**84.36%**
Combination #1	67.79%	60.19%	68.21%	72.69%	66.20%	**67.02%**
Human Papillomavirus Vaccine for Female Adolescents (hpv)	24.28%	14.58%	16.56%	26.16%	12.27%	**18.77%**
Combination #2	22.60%	13.43%	15.01%	24.54%	11.81%	**17.48%**
Lead Screening in Children (lsc)	68.51%	68.06%	65.12%	75.38%	72.22%	**69.86%**
Breast Cancer Screening (bcs)	60.50%	49.19%	NR	61.85%	53.53%	**56.27%**
Cervical Cancer Screening (ccs)	61.92%	52.47%	56.31%	66.50%	55.96%	**58.63%**
Chlamydia Screening in Women (chl)						
16-20 Years	55.14%	47.43%	52.27%	51.98%	54.60%	**52.28%**
21-24 Years	65.08%	61.76%	65.23%	63.23%	69.85%	**65.03%**
Total	58.53%	53.16%	55.24%	55.32%	59.02%	**56.25%**
EFFECTIVENESS OF CARE: RESPIRATORY CONDITIONS						
Appropriate Testing for Children with Pharyngitis (cwp)	74.30%	76.93%	74.14%	79.30%	78.74%	**76.68%**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (spr)	27.33%	28.74%	29.14%	32.90%	30.28%	**29.68%**
Pharmacotherapy Management of COPD Exacerbation (pce)						
Systemic Corticosteroid	56.65%	63.86%	56.77%	64.55%	50.36%	**58.44%**
Bronchodilator	83.43%	71.81%	71.88%	80.57%	79.47%	**77.43%**
Medication Management for People With Asthma (mma)						
5-11 Years - Medication Compliance 50%	47.96%	54.41%	50.24%	63.66%	48.61%	**52.98%**
5-11 Years - Medication Compliance 75%	20.43%	26.05%	25.18%	37.05%	20.74%	**25.89%**
12-18 Years - Medication Compliance 50%	43.52%	50.97%	46.64%	60.27%	43.98%	**49.08%**
12-18 Years - Medication Compliance 75%	20.47%	24.12%	20.39%	33.94%	12.65%	**22.31%**
19-50 Years - Medication Compliance 50%	45.60%	51.43%	52.34%	59.96%	55.70%	**53.01%**
19-50 Years - Medication Compliance 75%	25.27%	30.48%	28.04%	37.24%	16.46%	**27.50%**

Measure/Data Element	ATC	BlueChoice	Molina	Select	WellCare	Statewide Average
51-64 Years - Medication Compliance 50%	64.10%	60.61%	75.61%	70.83%	46.67%	**63.56%**
51-64 Years - Medication Compliance 75%	33.33%	39.39%	48.78%	52.78%	20.00%	**38.86%**
Total - Medication Compliance 50%	46.67%	53.27%	49.97%	62.33%	48.20%	**52.09%**
Total - Medication Compliance 75%	21.62%	26.52%	24.53%	36.35%	17.84%	**25.37%**
Asthma Medication Ratio (amr)						
5-11 Years	74.75%	82.57%	45.97%	69.20%	70.34%	**68.57%**
12-18 Years	60.33%	72.34%	71.43%	61.30%	58.29%	**64.74%**
19-50 Years	49.56%	51.75%	45.97%	53.30%	42.06%	**48.53%**
51-64 Years	62.50%	56.25%	71.43%	54.12%	52.38%	**59.34%**
Total	65.18%	73.77%	45.97%	64.50%	61.82%	**62.25%**
EFFECTIVENESS OF CARE: CARDIOVASCULAR CONDITIONS						
Controlling High Blood Pressure (cbp)	35.88%	41.92%	45.97%	50.69%	39.02%	**42.70%**
Persistence of Beta-Blocker Treatment After a Heart Attack (pbh)	65.38%	61.29%	71.43%	78.57%	76.92%	**70.72%**
Statin Therapy for Patients With Cardiovascular Disease (spc)						
Received Statin Therapy - 21-75 years (Male)	69.36%	74.59%	74.26%	79.33%	69.92%	**73.49%**
Statin Adherence 80% - 21-75 years (Male)	34.36%	55.80%	56.00%	63.38%	37.21%	**49.35%**
Received Statin Therapy - 40-75 years (Female)	66.31%	77.06%	70.30%	75.73%	72.90%	**72.46%**
Statin Adherence 80% - 40-75 years (Female)	29.84%	50.38%	53.45%	62.37%	30.77%	**45.36%**
Received Statin Therapy - Total	68.01%	75.77%	72.48%	77.48%	71.30%	**73.01%**
Statin Adherence 80% - Total	32.40%	53.16%	54.89%	62.87%	34.15%	**47.49%**
EFFECTIVENESS OF CARE: DIABETES						
Comprehensive Diabetes Care (cdc)						
Hemoglobin A1c (HbA1c) Testing	88.37%	83.10%	88.96%	92.37%	84.84%	**87.53%**
HbA1c Poor Control (>9.0%)	47.40%	47.92%	50.99%	47.93%	48.64%	**48.58%**
HbA1c Control (<8.0%)	41.49%	44.91%	40.62%	41.79%	41.40%	**42.04%**
HbA1c Control (<7.0%)	31.13%	NR	NR	32.08%	NR	**31.61%**

Measure/Data Element	ATC	BlueChoice	Molina	Select	WellCare	Statewide Average
Eye Exam (Retinal) Performed	54.34%	34.72%	59.16%	56.72%	39.14%	**48.82%**
Medical Attention for Nephropathy	93.06%	92.13%	92.72%	92.21%	92.53%	**92.53%**
Blood Pressure Control (<140/90 mm Hg)	46.88%	52.55%	50.11%	52.07%	43.44%	**49.01%**
Statin Therapy for Patients With Diabetes (spd)						
Received Statin Therapy	55.76%	60.64%	58.00%	58.18%	58.52%	**58.22%**
Statin Adherence 80%	33.92%	48.21%	49.10%	53.03%	41.76%	**45.20%**
EFFECTIVENESS OF CARE: MUSCULOSKELETAL CONDITIONS						
Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis (art)	65.55%	58.89%	68.32%	77.22%	71.67%	**68.33%**
EFFECTIVENESS OF CARE: BEHAVIORAL HEALTH						
Antidepressant Medication Management (amm)						
Effective Acute Phase Treatment	36.81%	42.53%	40.65%	49.76%	37.27%	**41.40%**
Effective Continuation Phase Treatment	22.17%	25.72%	25.78%	33.74%	24.91%	**26.46%**
Follow-Up Care for Children Prescribed ADHD Medication (add)						
Initiation Phase	53.02%	37.61%	45.69%	43.14%	42.41%	**44.37%**
Continuation and Maintenance (C&M) Phase	63.60%	51.68%	55.81%	28.79%	56.36%	**51.25%**
Follow-Up After Hospitalization for Mental Illness (fuh)						
30-Day Follow-Up	60.11%	NR	60.60%	43.14%	49.62%	**53.37%**
7-Day Follow-Up	40.43%	NR	41.76%	28.79%	28.46%	**34.86%**
Follow-Up After Emergency Department Visit for Mental Illness (fum)						
30-Day Follow-Up	55.64%	37.20%	56.24%	60.05%	53.07%	**52.44%**
7-Day Follow-Up	39.03%	24.86%	37.89%	44.55%	37.63%	**36.79%**
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (ssd)	76.80%	75.51%	78.70%	77.20%	75.10%	**76.66%**
Diabetes Monitoring for People With Diabetes and Schizophrenia (smd)	69.06%	69.23%	68.97%	66.20%	69.75%	**68.64%**
Cardiovascular Monitoring for People With Cardiovascular Disease	85.00%	66.67%	58.33%	70.59%	71.43%	**70.40%**

Measure/Data Element	ATC	BlueChoice	Molina	Select	WellCare	Statewide Average
and Schizophrenia (smc)						
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (saa)	55.84%	59.82%	71.67%	68.29%	63.17%	**63.76%**
Metabolic Monitoring for Children and Adolescents on Antipsychotics (apm)						
1-5 Years	12.50%	11.11%	50.00%	36.11%	NR	**27.43%**
6-11 Years	16.10%	18.97%	27.78%	20.66%	14.89%	**19.68%**
12-17 Years	29.69%	23.81%	25.23%	24.74%	25.32%	**25.76%**
Total	24.21%	21.76%	26.29%	23.56%	20.77%	**23.32%**
EFFECTIVENESS OF CARE: MEDICATION MANAGEMENT						
Annual Monitoring for Patients on Persistent Medications (mpm)						
ACE Inhibitors or ARBs	89.59%	86.94%	88.86%	88.23%	87.82%	**88.29%**
Digoxin	46.67%	55.00%	46.15%	47.30%	52.94%	**49.61%**
Diuretics	88.45%	87.00%	88.45%	88.03%	89.92%	**88.37%**
Total	88.74%	86.80%	88.37%	87.85%	88.52%	**88.06%**
EFFECTIVENESS OF CARE: OVERUSE/APPROPRIATENESS						
Non-Recommended Cervical Cancer Screening in Adolescent Females (ncs)	2.93%	1.56%	2.31%	1.66%	1.76%	**2.04%**
Appropriate Treatment for Children With URI (uri)	86.85%	84.40%	82.09%	84.29%	87.52%	**85.03%**
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis (aab)	31.25%	24.40%	25.71%	22.94%	27.01%	**26.26%**
Use of Imaging Studies for Low Back Pain (lbp)	66.48%	75.41%	66.21%	76.15%	68.13%	**70.48%**
Use of Multiple Concurrent Antipsychotics in Children and Adolescents (apc)						
1-5 Years	NR	NR	NR	NR	NR	**NA**
6-11 Years	0.00%	2.27%	0.00%	0.23%	0.00%	**0.50%**
12-17 Years	0.00%	0.00%	0.59%	0.28%	0.00%	**0.17%**
Total	0.00%	0.71%	0.37%	0.25%	0.00%	**0.27%**
ACCESS/AVAILABILITY OF CARE						
Adults' Access to Preventive/Ambulatory Health Services (aap)						
20-44 Years	77.75%	75.74%	77.24%	80.67%	76.48%	**77.58%**

Measure/Data Element	ATC	BlueChoice	Molina	Select	WellCare	Statewide Average
45-64 Years	86.38%	85.99%	88.56%	89.81%	84.92%	**87.13%**
65+ Years	100.00%	100.00%	100.00%	92.31%	100.00%	**98.46%**
Total	80.24%	78.79%	81.06%	82.83%	79.27%	**80.44%**
Children and Adolescents' Access to Primary Care Practitioners (cap)						
12-24 Months	95.52%	96.08%	95.95%	97.27%	95.23%	**96.01%**
25 Months - 6 Years	85.32%	85.99%	85.89%	88.29%	83.50%	**85.80%**
7-11 Years	88.58%	87.49%	89.54%	91.75%	86.43%	**88.76%**
12-19 Years	87.01%	85.73%	88.60%	90.28%	83.58%	**87.04%**
Initiation and Engagement of AOD Dependence Treatment (iet)						
Initiation of AOD Treatment: 13-17 Years	32.41%	31.52%	38.37%	NB	33.33%	**33.91%**
Engagement of AOD Treatment: 13-17 Years	15.17%	14.13%	24.42%	NB	17.20%	**17.73%**
Initiation of AOD Treatment: 18+ Years	39.84%	36.40%	35.51%	NB	38.89%	**37.66%**
Engagement of AOD Treatment: 18+ Years	8.83%	9.59%	7.91%	NB	7.94%	**8.57%**
Initiation of AOD Treatment: Total	39.33%	36.12%	35.80%	NB	38.51%	**37.44%**
Engagement of AOD Treatment: Total	9.26%	9.85%	9.61%	NB	8.57%	**9.32%**
Prenatal and Postpartum Care (ppc)						
Timeliness of Prenatal Care	90.09%	89.56%	89.83%	89.94%	91.73%	**90.23%**
Postpartum Care	67.69%	70.53%	70.72%	75.30%	66.93%	**70.23%**
Call Answer Timeliness (cat)	NR	NR	NR	NR	NR	**NA**
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (app)						
1-5 Years	NR	NR	NR	NR	NR	**NA**
6-11 Years	60.34%	48.39%	64.91%	67.01%	54.84%	**59.10%**
12-17 Years	56.58%	24.59%	58.02%	64.19%	39.39%	**48.55%**
Total	58.57%	35.35%	60.00%	65.05%	46.27%	**53.05%**
UTILIZATION						
Frequency of Ongoing Prenatal Care (fpc)						
<21 Percent	2.83%	9.56%	1.99%	5.18%	0.52%	**4.02%**
21-40 Percent	2.36%	4.11%	1.49%	1.83%	3.10%	**2.58%**
41-60 Percent	6.37%	7.88%	3.23%	6.71%	5.17%	**5.87%**

Measure/Data Element	ATC	BlueChoice	Molina	Select	WellCare	Statewide Average
61-80 Percent	12.74%	15.22%	9.93%	8.23%	11.63%	**11.55%**
81+ Percent	75.71%	63.23%	83.37%	78.05%	79.59%	**75.99%**
Well-Child Visits in the First 15 Months of Life (w15)						
0 Visits	1.92%	2.78%	0.68%	1.06%	1.62%	**1.61%**
1 Visit	1.44%	2.31%	1.58%	1.32%	1.62%	**1.65%**
2 Visits	2.40%	3.01%	4.07%	1.06%	2.31%	**2.57%**
3 Visits	6.49%	3.24%	3.17%	4.50%	5.32%	**4.54%**
4 Visits	10.34%	9.72%	12.22%	5.03%	8.80%	**9.22%**
5 Visits	17.31%	10.65%	17.42%	14.29%	20.83%	**16.10%**
6+ Visits	60.10%	68.29%	60.86%	72.75%	59.49%	**64.30%**
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (w34)	59.33%	66.17%	57.85%	72.58%	58.96%	**62.98%**
Adolescent Well-Care Visits (awc)	52.88%	47.45%	40.62%	58.70%	41.67%	**48.26%**

NR = measure not reported; NA= not available; NB= not a benefit

Performance Improvement Project Validation

Each health plan is required to submit its PIPs (or QI projects) to CCME annually for review. CCME validates and scores the submitted projects using a CMS designed protocol that evaluates the validity and confidence in the results of each project. The ten projects reviewed in 2017-2018 for the five plans are displayed in *Table 7, Results of the Validation of PIPs*.

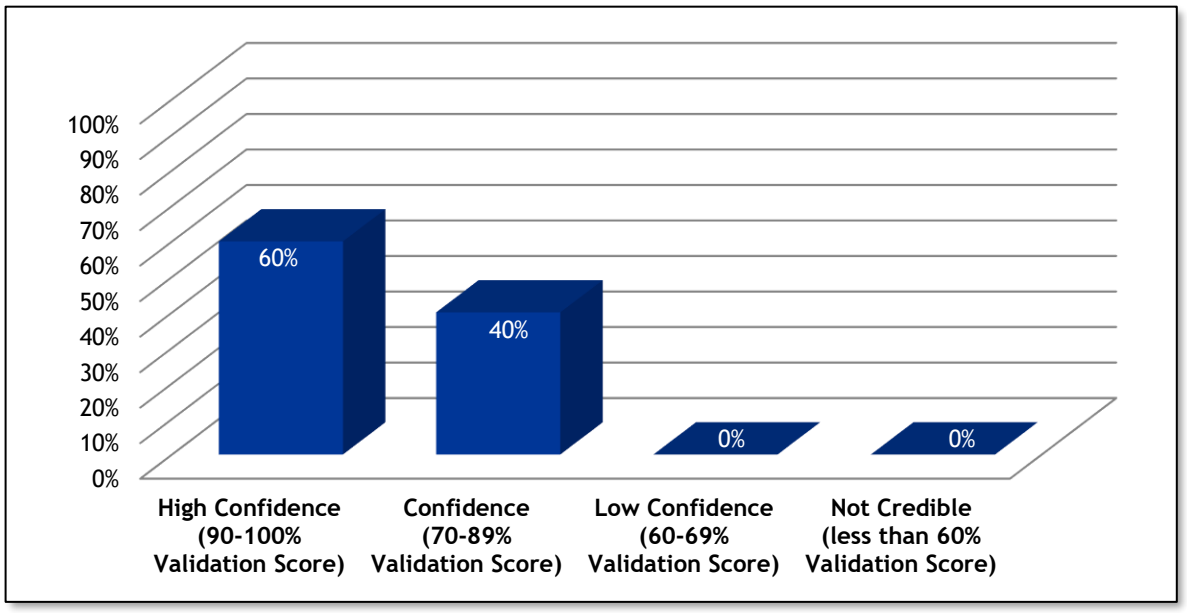
Table 7: Results of the Validation of PIPs

Project	Validation Score
ATC	
Member Satisfaction	95% High Confidence in Reported Results
Retinal or Dilated Eye Exam	100% High Confidence in Reported Results
BlueChoice	
Access and Availability of Care	83% Confidence in Reported Results

Project	Validation Score
Childhood Immunizations Combo 3 and Lead Screenings	83% Confidence in Reported Results
Molina	
Well Care	94% High Confidence in Reported Results
Improving Claims Accuracy and Provider Satisfaction	73% Confidence in Reported Results
Select	
Diabetes Outcomes Measures	93 % High Confidence in Reported Results
Follow-Up After Hospitalization for Mental Health Within 7 and 30 Calendar Days After Discharge	88 % Confidence in Reported Results
WellCare	
Access to Care	100% High Confidence in Reported Results
Improving Hemoglobin A1C Testing	100% High Confidence in Reported Results

Figure 10: Percent of Performance Improvement Projects displays the aggregated validation scores for the PIPs across all five measured plans. Of the ten projects, six were scored in the high confidence range and four projects were scored in the confidence range. No projects were in the low confidence or not credible range.

Figure 10: Percent of Performance Improvement Projects



Issues for PIPs

CCME found varying issues with PIP reporting across the plans. Such issues included lack of data analysis to support study rationale, incorrect data methodology reporting, lack of information regarding staff/personnel involved in data collection and calculation, inappropriate reporting on benchmark and baseline goal rates, and lack of improvement in the measures of interest. CCME provided recommendations to each plan to improve documentation for the next review cycle. In addition, each plan was referred to the *CMS Protocol, Validation of Performance Improvement Projects* as a guide for the PIP reports.

Overall, the plans performed well in the Quality Improvement section. BlueChoice was not monitoring provider compliance with its clinical and preventive practice guidelines. BlueChoice and Molina had projects that did not meet the validation requirements. *Figure 11 and Table 8* provide an overview of plan performance in the Quality Improvement section.

Figure 11: Quality Improvement

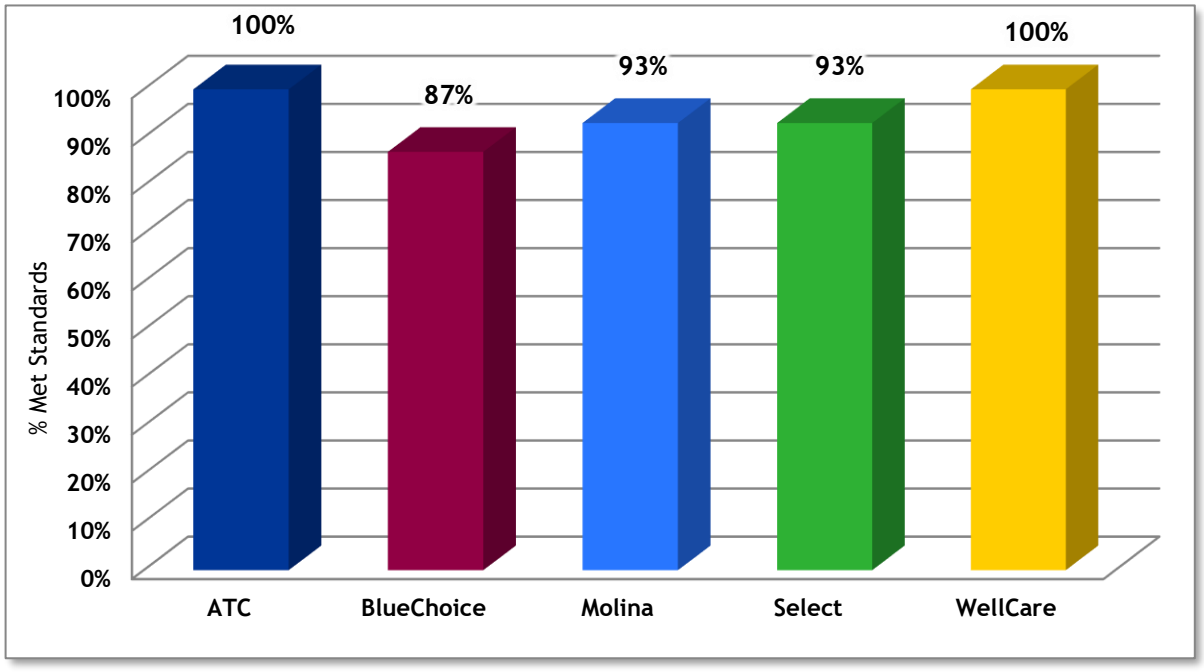


Table 8: Quality Improvement Comparative Data

Standard	ATC	BlueChoice	Molina	Select	WellCare
The Quality Improvement (QI) Program					
The MCO formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to members	Met	Met	Met	Met	Met
The scope of the QI program includes monitoring of provider compliance with MCO wellness care and disease management guidelines	Met	Partially Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
The scope of the QI program includes investigation of trends noted through utilization data collection and analysis that demonstrate potential health care delivery problems	Met	Met	Met	Met	Met
An annual plan of QI activities is in place which includes areas to be studied, follow up of previous projects where appropriate, timeframe for implementation and completion, and the person(s) responsible for the project(s)	Met	Met	Met	Met	Met
Quality Improvement Committee					
The MCO has established a committee charged with oversight of the QI program, with clearly delineated responsibilities	Met	Met	Met	Met	Met
The composition of the QI Committee reflects the membership required by the contract	Met	Met	Met	Met	Met
The QI Committee meets at regular quarterly intervals	Met	Met	Met	Met	Met
Minutes are maintained that document proceedings of the QI Committee	Met	Met	Met	Met	Met
Performance Measures					
Performance measures required by the contract are consistent with the requirements of the CMS protocol Validation of Performance Measures	Met	Met	Met	Met	Met
Quality Improvement Projects					

Standard	ATC	BlueChoice	Molina	Select	WellCare
Topics selected for study under the QI program are chosen from problems and/or needs pertinent to the member population	Met	Met	Met	Met	Met
The study design for QI projects meets the requirements of the CMS Protocol, Validating of Performance Improvement Projects	Met	Partially Met	Partially Met	Partially Met	Met
Provider Participation in QI Activities					
The MCO requires its providers to actively participate in QI activities	Met	Met	Met	Met	Met
Providers receive interpretation of their QI performance data and feedback regarding QI activities	Met	Met	Met	Met	Met
Annual Evaluation of the QI Program					
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met	Met	Met	Met	Met
The annual report of the QI program is submitted to the QIC and to the MCO Board of Directors	Met	Met	Met	Met	Met

Strengths

- All the plans have a QI Committee with clearly delineated responsibilities charged with oversight of the QI Program.

Weaknesses

- Issues with PIP reporting across the plans included lack of data analysis to support study rationale, incorrect data methodology reporting, lack of information regarding staff/personnel involved in data collection and calculation, inappropriate reporting on

benchmark and baseline goal rates, and lack of improvement in the measures of interest.

Recommendations

- Improve the PIP documentation for the next review cycle. In addition, refer to the CMS Protocol, *Validation of Performance Improvement Projects* as a guide for PIP reports.

E. Utilization Management

Each of the health plans has a Utilization Management (UM) program description that is specific to the Medicaid line of business and defines program structures, lines of authority, goals, objectives, and staff roles. UM policies and procedures provide staff with specific requirements and detailed processes for conducting UM functions. Along with program descriptions and policies, UM processes and requirements are included in the plans' Member Handbooks, Provider Manuals, and websites. Reviews of these information sources revealed errors, discrepancies, and omissions of information. CCME discussed these issues with the plans during the onsite visits and advised plans of needed corrections along with citations to the applicable SCDHHS Contract and Federal Regulations.

The *SCDHHS Contract, Section 8.4.2.7*, requires the health plans to develop a preferred provider program based on quality that results in eligibility for special considerations, such as exemption from service authorization requirements, expedited service authorization processes, or simplified documentation requirements for the authorization process. Except for Select, each of the plans submitted evidence of compliance with this requirement. CCME recommends that BlueChoice and Molina include a description of the Preferred Provider Program in the *Provider Manual* and other provider resources. Select stated during the onsite visit that it would provide information demonstrating compliance with the requirement for a preferred provider program; however, CCME did not receive this documentation.

UM approval and denial files confirmed the plans use appropriate criteria to evaluate medical necessity and additional clinical information is requested as needed for review. Most medical necessity determinations and notifications were timely. Most Adverse Benefit Determination letters used appropriate language; however, CCME noted a few issues in the content of the *Notice of Adverse Benefit Determination* letters, including failure to indicate the specific service or date of service denied (Molina) and failure to include the specific criteria used for review (Select and WellCare).

The plans have established policies and procedures for handling appeals of adverse benefit determinations. Processes for filing and handling appeals are also documented in

Member Handbooks, Provider Manuals, plan websites, etc. Appeals documentation reveals the following issues:

- Use of incorrect terminology and incomplete information when defining appeals and related terms (ATC, Select, WellCare)
- Outdated *Appointment of Authorized Representative* form on the website (ATC)
- Incomplete information in policy and on the website regarding representatives filing appeals on a member's behalf (Molina)
- Errors and discrepancies in documentation of the timeframe to file an appeal (ATC, BlueChoice, Select, WellCare)
- Incomplete/incorrect information about appeal resolution timeframes and extensions of appeal resolution timeframes (BlueChoice, WellCare)
- Errors in the timeframe to request a State Fair Hearing (Molina)
- Incorrect information about requesting continuation of benefits pending the outcome of an appeal or State Fair Hearing (Select)

CCME's review of appeals files confirmed that despite the issues with documentation of appeal processes, appropriate appeals handling processes and requirements are followed. Several minor issues were noted, including an incorrect reviewer specialty in one letter (ATC), two late acknowledgements (Select), and discrepancies in documentation of the receipt date for three appeals (Select).

Each of the health plans has established Case Management (CM) programs to ensure comprehensive, coordinated care for members with high risk and complex needs as well as those experiencing a transition of care. Program descriptions and policies provide direction to staff in conducting CM functions for members. Potential candidates for CM are identified through multiple methods, including but not limited to predictive modeling, data mining, and internal and external referrals. The *SCDHHS Contract, Section 5.6.2* requires the designation of a person with appropriate training and experience to act as Transition Coordinator, but the desk material review as well as onsite discussion indicated BlueChoice has not designated a Transition Coordinator to meet this requirement. CM file review for all plans confirmed appropriate CM processes are followed and appropriate functions are conducted. All the plans have processes to measure member satisfaction with case management.

The percentages of "Met" scores for the Utilization Management section of the review are illustrated in *Figure 12: Utilization Management*. A comparison of all scores for the Utilization Management section is illustrated in *Table 9: Utilization Management Comparative Data*. Three of the plans show improvement in the percentage of "Met" scores in the UM section of the review (ATC, BlueChoice, Molina) while Select's

percentage of "Met" scores is unchanged, and WellCare experienced a decrease in the percentage of "Met" scores.

Figure 12: Utilization Management

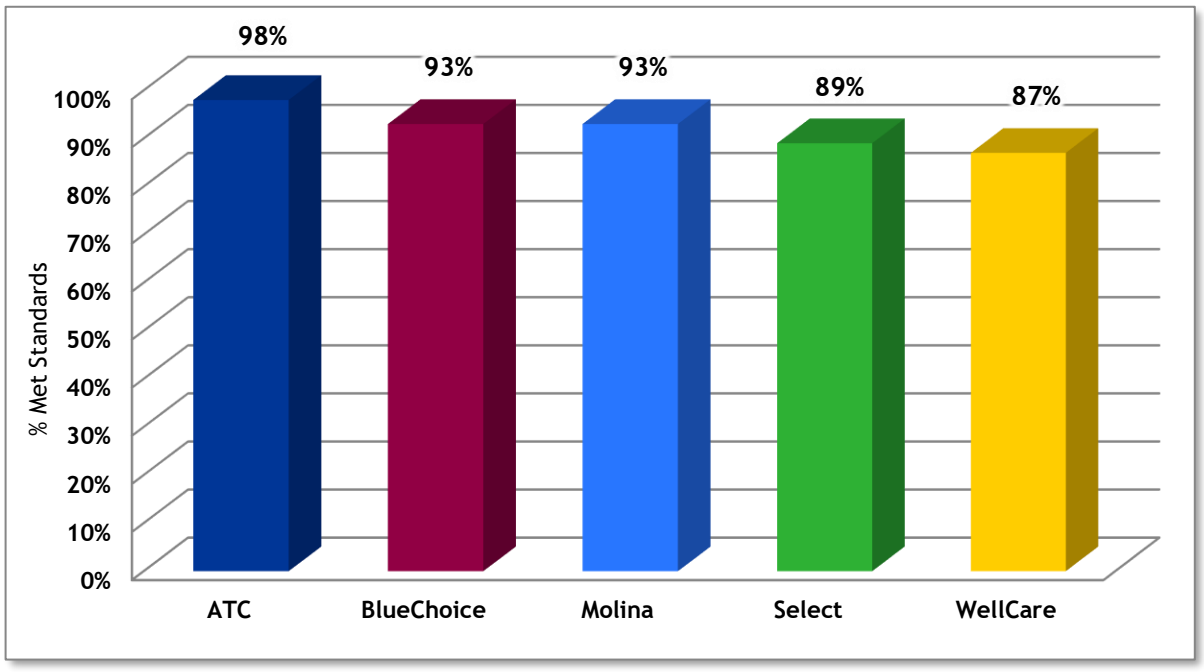


Table 9: Utilization Management Comparative Data

Standard	ATC	BlueChoice	Molina	Select	WellCare
The Utilization Management (UM) Program					
The MCO formulates and acts within policies and procedures that describe its utilization management program, including but not limited to	Met	Met	Met	Met	Met
structure of the program and methodology used to evaluate the medical necessity	Met	Met	Met	Met	Met
lines of responsibility and accountability	Met	Met	Met	Met	Met
guidelines / standards to be used in making utilization management decisions	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
timeliness of UM decisions, initial notification, and written (or electronic) verification	Met	Met	Partially Met	Partially Met	Partially Met
consideration of new technology	Met	Met	Met	Met	Met
the absence of direct financial incentives or established quotas to provider or UM staff for denials of coverage or services	Met	Met	Met	Met	Met
the mechanism to provide for a preferred provider program	Met	Met	Met	Partially Met	Met
Utilization management activities occur within significant oversight by the Medical Director or the Medical Director's physician designee	Met	Met	Met	Met	Met
The UM program design is periodically reevaluated, including practitioner input on medical necessity determination guidelines and grievances and/or appeals related to medical necessity and coverage decisions	Met	Met	Met	Met	Met
Medical Necessity Determinations					
Utilization management standards/criteria used are in place for determining medical necessity for all covered benefit situations	Met	Met	Met	Met	Met
Utilization management decisions are made using predetermined standards/criteria and all available medical information	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
Coverage of hysterectomies, sterilizations and abortions is consistent with state and federal regulations	Met	Met	Met	Met	Met
Utilization management standards/criteria are reasonable and allow for unique individual patient decisions	Met	Met	Met	Met	Met
Utilization management standards/criteria are consistently applied to all members across all reviewers	Met	Met	Partially Met	Met	Met
Any pharmacy formulary restrictions are reasonable and are made in consultation with pharmaceutical experts	Met	Met	Met	Met	Met
If the MCO uses a closed formulary, there is a mechanism for making exceptions based on medical necessity	Met	Met	Met	Met	Met
Emergency and post stabilization care are provided in a manner consistent with the contract and federal regulations	Met	Met	Met	Met	Partially Met
Utilization management standards/criteria are available to providers	Met	Met	Met	Met	Met
Utilization management decisions are made by appropriately trained reviewers	Met	Met	Met	Met	Met
Initial utilization decisions are made promptly after all necessary information is received	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
A reasonable effort that is not burdensome on the member or the provider is made to obtain all pertinent information prior to making the decision to deny services	Met	Met	Met	Met	Met
All decisions to deny services based on medical necessity are reviewed by an appropriate physician specialist	Met	Met	Met	Met	Met
Denial decisions are promptly communicated to the provider and member and include the basis for the denial of service and the procedure for appeal	Met	Met	Met	Met	Partially Met
Appeals					
The MCO formulates and acts within policies and procedures for registering and responding to member and/or provider appeals of an adverse benefit determination by the MCO in a manner consistent with contract requirements, including	Met	Met	Met	Met	Met
The definitions of an adverse benefit determination and an appeal and who may file an appeal	Partially Met	Met	Met	Partially Met	Partially Met
The procedure for filing an appeal	Met	Partially Met	Met	Partially Met	Partially Met
Review of any appeal involving medical necessity or clinical issues, including examination of all original medical information as well as any new information, by a practitioner with the appropriate medical expertise who has not previously reviewed the case	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
A mechanism for expedited appeal where the life or health of the member would be jeopardized by delay	Met	Met	Met	Met	Met
Timeliness guidelines for resolution of the appeal as specified in the contract	Met	Partially Met	Met	Met	Partially Met
Written notice of the appeal resolution as required by the contract	Met	Met	Partially Met	Met	Met
Other requirements as specified in the contract	Met	Met	Met	Partially Met	Met
The MCO applies the appeal policies and procedures as formulated	Met	Met	Met	Met	Met
Appeals are tallied, categorized, analyzed for patterns and potential quality improvement opportunities, and reported to the Quality Improvement Committee	Met	Met	Met	Met	Met
Appeals are managed in accordance with the MCO confidentiality policies and procedures	Met	Met	Met	Met	Met
Case Management (CM)					
The MCO formulates policies and procedures that describe its case management/care coordination programs	Met	Met	Met	Met	Met
The MCO has processes to identify members who may benefit from case management	Met	Met	Met	Met	Met
The MCO provides care management activities based on the member's risk stratification	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
The MCO utilizes care management techniques to ensure comprehensive, coordinated care for all members	Met	Met	Met	Met	Met
The MCO has developed and implemented policies and procedures that address transition of care	Met	Met	Met	Met	Met
The MCO has a designated Transition Coordinator who meets contract requirements	Met	Not Met	Met	Met	Met
The MCO measures case management performance and member satisfaction, and has processes to improve performance when necessary	Met	Met	Met	Met	Met
Care management and coordination activities are conducted as required	Met	Met	Met	Met	Met
Evaluation of Over/ Underutilization					
The MCO has mechanisms to detect and document under and over utilization of medical services as required by the contract	Met	Met	Met	Met	Met
The MCO monitors and analyzes utilization data for under and over utilization	Met	Met	Met	Met	Met

Strengths

- Health plan websites are a resource for members and providers to obtain information regarding UM requirements and processes as well as manuals, handbooks, forms, etc.
- All the health plans have well-developed CM programs for members with complex and high-risk needs. CM files provide evidence that Case Managers thoroughly document services they provide to ensure comprehensive, coordinated care for members.

Weaknesses

- Molina, Select, and WellCare have errors, omissions, and discrepancies in documentation of UM authorization timeliness requirements.
- Select does not demonstrate compliance with the contractual requirement for a Preferred Provider Program.
- Molina's policies do not accurately reflect its processes for inter-rater reliability testing to ensure consistency in application of medical necessity criteria.
- WellCare does not include all requirements for emergency and post-stabilization coverage in policy.
- All the health plans have errors, discrepancies, and omissions in documentation of appeals information, requirements, timeframes, and processes.
- Several adverse benefit determination letters in WellCare's denial files did not include the medical necessity criteria used in the review.
- BlueChoice does not have a designated Transition Coordinator as required by the *SCDHHS Contract, Section 5.6.2*.

Recommendations

- Plans should ensure documentation of UM and appeals requirements and processes is correct and complete, and that adverse benefit determination letters contain all required information.
- CCME recommends that Select thoroughly document and implement a program to comply with contractual requirements for a Preferred Provider Program.
- CCME recommends that BlueChoice designate an appropriate staff member as Transition Coordinator to comply with the requirements of the *SCDHHS Contract, Section 5.6.2*.

F. Delegation

Each of the MCOs has established policies that define requirements and processes for delegation of MCO functions to other entities. The policies address required written agreements to specify the functions delegated, requirements for pre-delegation assessments, annual and ongoing monitoring and oversight of delegate performance, and development of corrective action plans for substandard delegate performance. The health plans use delegation oversight audit tools to monitor and oversee delegate performance.

Policies and tools revealed several issues. Select policies had outdated language for delegated credentialing requirements for primary care physicians and outdated

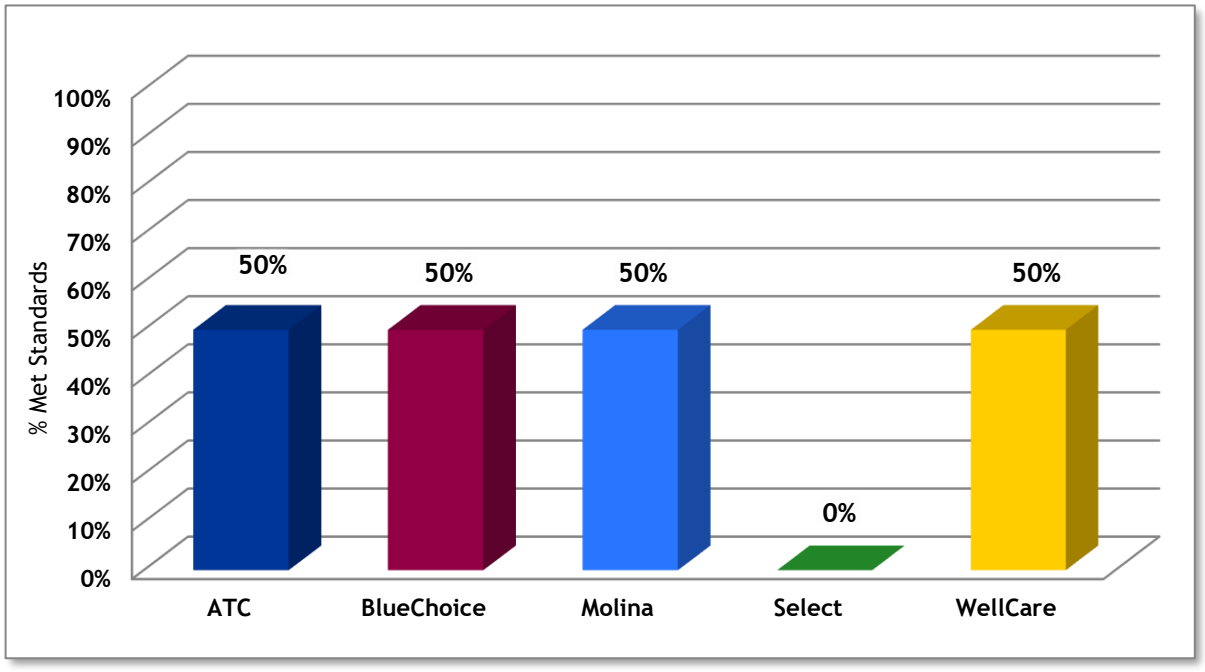
references to the *SCDHHS Contract*. BlueChoice and ATC had incomplete information regarding required queries for credentialing and discrepancies in audit tools used to monitor delegate performance.

Each plan's documentation of delegate oversight confirmed oversight activities are conducted for all entities, but some issues were noted in documentation, including:

- ATC appeared to use a delegation audit tool for another state. For one delegate, the annual oversight results letter indicated the delegate scored 100% for compliance for its oversight audit despite documenting the delegate was not collecting the required ownership disclosure forms (ODF) and was not querying the *Social Security Death Master File* (SSDMF) as required. No evidence was presented that ATC acted to ensure the delegate addressed the deficiencies.
- Molina had inconsistencies in scoring between the entities related to the SSDMF. Some delegates were given a score of 100% with a note the SSDMF was not included, and other delegates were scored 0% indicating non-compliance for the SSDMF. Some of the delegates were placed under a Corrective Action Plan for this issue and some were simply given a Recommendation. The audit tool for one delegate indicated an inappropriate comment of "N/A" for evidence of the ownership disclosure form in a credentialing file.
- Select did not indicate that the ownership disclosure forms were reviewed for two delegates. Also, an Executive Summary indicated that a credentialing file review was not completed due to a delegate's NCQA CVO certification, and there was no evidence that SC credentialing criteria were considered in the oversight of this delegate.
- For one delegate, WellCare had inconsistencies in scoring credentialing and recredentialing file audits related to evidence of ownership disclosure forms (ODF). Numerous issues were noted in oversight of multiple delegates related to requirements for ODF, Clinical Laboratory Improvement Amendments (CLIA) certificates, and requirements for out-of-state providers who service South Carolina patients. During onsite discussion of these issues, WellCare indicated additional training may be needed for employees that conduct delegation oversight reviews.

Figure 13: Delegation, illustrates each plan's percentage of "Met" scores for the review.

Figure 13: Delegation



A comparison of the plans' scores for the standards in the Delegation section is illustrated in *Table 11: Delegation Comparative Data*.

Table 11: Delegation Comparative Data

Standard	ATC	BlueChoice	Molina	Select	WellCare
The MCO has written agreements with all contractors or agencies performing delegated functions that outline responsibilities of the contractor or agency in performing those delegated functions	Met	Met	Met	Partially Met	Met
The MCO conducts oversight of all delegated functions sufficient to ensure that such functions are performed using those standards that would apply to the MCO if the MCO were directly performing the delegated functions	Partially Met	Partially Met	Partially Met	Partially Met	Partially Met

Strengths

- All the MCOs require written delegation agreements and conduct pre-delegation review to confirm delegates can conduct the delegated functions.

Weaknesses

- Issues in the MCOs' policies and/or tools include:
  - Sample audit tools do not match the actual tool used and do not include all South Carolina-specific credentialing requirements (ATC)
  - Failure to include the SSDMF and the *Terminated for Cause List* as a required query for credentialing (BlueChoice)
  - Outdated SCDHHS Contract/P&P Guide requirements for credentialing in the delegate audit tool (Select)
  - References to other policies that were retired (WellCare)
- Documentation of delegate oversight revealed several issues including:
  - Use of incorrect or incomplete audit tools (ATC, Select, WellCare)
  - Inconsistencies in or improper scoring of audit tools (ATC, Molina, WellCare)
  - Lack of evidence that all required oversight activities were conducted (Select)

Recommendations

- The plans should ensure delegation policies and delegation audit tools include all contractual requirements.
- The plans should conduct all required delegation oversight activities, ensure all South Carolina specific credentialing elements are included, and verify that scoring is consistent for each delegate.

G. State Mandated Services

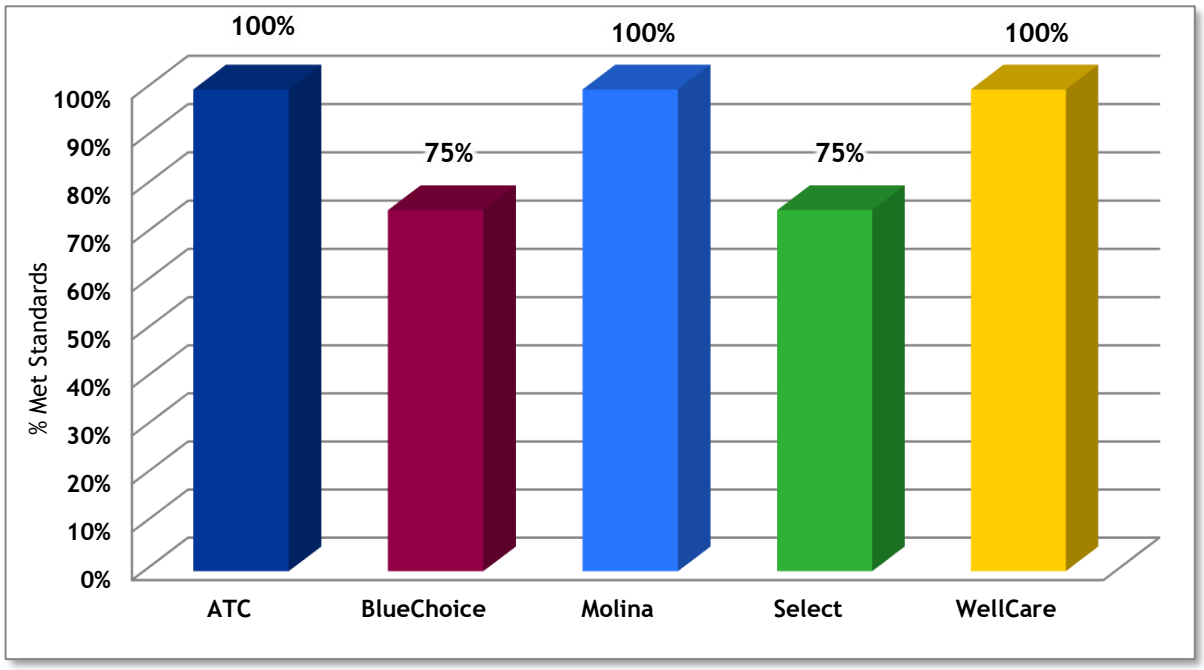
CCME's review of the State-Mandated Services section focuses on ensuring the plans provide core benefits required by the *SCDHHS Contract* and that each of the MCOs adequately addresses deficiencies identified in its previous EQR.

All the MCO plans provide the required core benefits and have established Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Programs that encourage providers to make sure mandated services are provided to members from birth through the month of their 21st birthday. Providers are educated about the EPSDT Program, including appropriate immunizations, and compliance is monitored by the plans through claims analysis and medical record reviews.

During the previous EQR, each of the plans submitted quality improvement plans to address identified deficiencies. WellCare, ATC and Molina implemented all proposed changes; however, BlueChoice and Select had uncorrected quality improvement plan deficiencies from the previous EQR.

Each plan's percentage of "Met" scores is demonstrated in *Figure 14: State-Mandated*.

Figure 14: State-Mandated



A comparison of the plans' scores for the standards in the State-Mandated Services section is illustrated in *Table 12: State-Mandated Comparative Data*.

Table 12: State-Mandated Comparative Data

Standard	ATC	BlueChoice	Molina	Select	WellCare
The MCO tracks provider compliance with administering required immunizations	Met	Met	Met	Met	Met
Performing EPSDTs/Well Care	Met	Met	Met	Met	Met
Core benefits provided by the MCO include all those specified by the contract	Met	Met	Met	Met	Met

Standard	ATC	BlueChoice	Molina	Select	WellCare
The MCO addresses deficiencies identified in previous independent external quality reviews	Met	Not Met	Met	Not Met	Met

Weaknesses

- Two of the MCOs did not fully implement all corrections of deficiencies identified in the previous EQR.

Recommendations

- Address deficiencies identified in current and prior EQRs.

H. South Carolina Solutions

South Carolina Solutions (Solutions) is contracted with SCDHHS to provide primary care case management and care coordination for the Medially Complex Children's Waiver Program (MCCW). This review focused on administrative functions, committee minutes, member and provider demographics, member and provider educational materials, and the Quality Improvement and Care Coordination/Case Management Programs.

Solutions organizational chart, leadership and staffing appears sufficient to conduct all required services for participants. The Compliance Officer/Privacy Officer oversees, investigates, and manages all aspects of the Compliance Program and investigates allegations of privacy violations. Employees are provided with compliance and confidentiality training upon hire and annually thereafter. Provider compliance training is provided by the Program Operations Coordinator.

Policies and procedures address processes for securing and managing PHI, including how access to PHI is managed, such as access authorization, access revocation, authorization conditions, and retention of authorization documentation. Appropriate disaster recovery plans are in place and Solutions provided evidence of a recent recovery effort that resulted in a successful system restoration.

For Provider Services, CCME reviewed documents and reference materials used by the plan to educate contracted providers. The Provider Orientation/Training policy defines a consistent process for onboarding new providers to the company's physician network. The Program Operations Coordinator provides the practice with orientation and training within 30 days of contracting with the company. The *Provider Manual* is used to educate providers on the MCCW program and contractual obligations.

In the Quality Improvement section, Solutions submitted its *2018 Strategic Quality Plan*, work plans, committee minutes, and their *Annual Report: Quality and Performance Improvement Calendar Year 2017* to demonstrate the program in place to improve the care and services provided to members and providers. CCME found no deficiencies in the Quality Improvement section. Recommendations to update the *Strategic Quality Plan*, the work plan, committee minutes, and the committee membership list were offered.

Solutions' policies address care coordination processes and frequency of services provided. Review of case management files indicate Care Coordinators and Care Advocates follow policies as outlined. Documentation reflects provider offices are actively involved in reviewing participant's service plans. The files also indicate quarterly visits are consistently completed; however, team conferences are rarely noted. CCME recommends correcting the frequency of team conferences in policies and improve the documentation in the case management files regarding team conferences.

An overview of the scores for Solutions is illustrated in *Table 13: Solutions Scores by Review Section*

Table 13: Solutions Scores by Review Section

Standard	Solutions
ADMINISTRATION/ORGANIZATION ACTIVITIES	
Policies and procedures are organized, reviewed, and available to staff	Met
The organization's infrastructure complies with contract requirements. At a minimum, this includes designated staff performing the following activities: Administrative oversight of day-to-day activities of the organization and available per contract requirements	Met
Care coordination and enhanced case management	Met
Provider services and education	Met
Quality assurance	Met
Designated compliance officer	Met
PROVIDER SERVICES	
The organization formulates and acts within policies and procedures related to initial and ongoing education of providers	Met
Initial provider education includes Organization structure, operations, and goals	Met
Provider responsibilities and procedures for obtaining authorization from the state for services and referrals, as needed	Met

Standard	Solutions
Medical record documentation requirements, handling, availability, retention, and confidentiality	Met
How to access language interpretation services	Met
The organization provides ongoing education to providers regarding changes and/or additions to its programs, practices, standards, policies and procedures	Met
QUALITY IMPROVEMENT	
The organization formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to participants	Met
An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity	Met
The organization formulates and implements a formal quality improvement program with clearly defined goals, structure, scope and methodology directed at improving the quality of health care delivered to participants	Met
An annual QI work plan is in place which includes activities to be conducted, follow up of any previous activities where appropriate, timeframe for implementation and completion, and the person(s) responsible for the activity	Met
A written summary and assessment of the effectiveness of the QI program for the year is prepared annually	Met
The annual report of the QI program is submitted to the QI Committee	Met
CARE COORDINATION/CASE MANAGEMENT	
The organization formulates and acts within written policies and procedures and/or a program description that describe its care coordination and case management programs	Met
Policies and procedures and/or the program description address the following: Structure of the program	Met
Lines of responsibility and accountability	Met
Goals and objectives of Care Coordination/Case Management	Met
Intake and assessment processes for Care Coordination/Case Management	Met
Provision of required information to participants at the time of enrollment	Met
Minimum standards for phone contacts, in-home visits, and physician/nurse plan oversight as applicable	Partially Met
Processes to develop, implement, coordinate, and monitor individual care coordination plan with the participant/caregivers and the PCP	Met

Standard	Solutions
Processes to ensure caregiver/parent participation in and understanding of the Care Coordination Plan	Met
Process to regularly update and evaluate the care coordination plan on an ongoing basis	Met
Processes for following up with participants admitted to the hospital and actively participate in discharge planning	Met
Processes for reporting suspected abuse, neglect, or exploitation of a participant	Met
A back-up service provision plan to ensure that the Participant receives the authorized care coordination services and a process to notify SCDHHS if services cannot be provided	Met
The organization provides a written, formal evaluation of the Service Plan to SCDHHS every 6 months or upon request	Met
The organization conducts Care Coordination and Case Management functions as required by the contract	Partially Met

Strengths

- Disaster recovery and business continuity documentation is thorough and includes contact information for external resources.
- The *Provider Manual* is detailed and contains sufficient information for providers to navigate the plan.
- Solutions provided the *2018 Strategic Quality Plan* as evidence of the plan designed to provide the structure and key processes for ongoing improvements of care and services.
- Case Management files indicate Spanish-language materials are provided to participants as needed.

Weaknesses

- Discrepancies are noted in policies regarding the frequency of team conferences.
- Case Management files indicate quarterly visits are consistently completed; however, team conferences are rarely noted.

Recommendations

- Ensure the correct requirement for frequency of team conferences is noted in policies and reflected in Case Management file documentation.

FINDINGS SUMMARY

Overall, SC Solutions demonstrated improvements in all areas reviewed for the review conducted for contract year 2017–2018. *Table 14: Annual Review Comparisons* reflects the total percentage of standards scored as "Met" for the 2017 through 2018 EQR. The percentages highlighted in green indicate an improvement over the prior review findings. Those highlighted in yellow represent a reduction in the prior review findings. Areas reviewed for the MCOs that are not applicable for Solutions is noted as Not Applicable (NA).

Table 14: Annual Review Comparisons

	ATC		BLUECHOICE		MOLINA		SOLUTIONS		SELECT		WELLCARE	
	2016	2017	2017	2018	2017	2018	2017	2018	2016	2017	2016	2018
Administration	100%	100%	93.9%	97% ↑	91%	100% ↑	86%	100% ↑	100%	100%	97%	100% ↑
Provider Services	95%	91% ↓	92%	85% ↓	92%	86% ↓	50%	100% ↑	89%	88% ↓	94%	91% ↓
Member Services	95%	94% ↓	94.6%	85% ↓	95%	88% ↓	NA	NA	92%	94% ↑	95%	91% ↓
Quality Improvement	100%	100%	100%	87% ↓	87%	93% ↑	86%	100% ↑	93%	93%	100%	100%
*Utilization Management	97%	98% ↑	92.1%	93% ↑	87%	93% ↑	53%	87% ↑	89%	89%	92%	87% ↓
Delegation	100%	50% ↓	100%	50% ↓	100%	50% ↓	NA	NA	100%	0% ↓	50%	50%
State Mandated Services	100%	100%	75%	75%	75%	100% ↑	NA	NA	75%	75%	100%	100%

*Care Coordination/Case Management for Solutions

Coordinated and Integrated Care Organization Annual Review

At the request of the South Carolina Department of Health and Human Services (SCDHHS), The Carolinas Center for Medical Excellence (CCME) conducted an External Quality Review (EQR) of the Coordinated and Integrated Care Organizations (CICO). Those organizations included Absolute Total Care (ATC), Molina Healthcare of South Carolina (Molina) and Select of South Carolina (Select). The review focused on the following four areas:

- Home and Community Based Services and Behavioral Health Provider Network Adequacy
- Evaluation of Over/Under Utilization
- Care Transitions
- Quality Improvement Projects

To conduct the review, CCME requested desk materials from each CICO. These items focus on administrative functions, committee minutes, member and provider demographics, over and under-utilization data, care transition files, and performance improvement projects (PIPs).

Findings

CCME identifies areas of review as meeting a standard ("Met"), acceptable but needing improvement ("Partially Met") or failing a standard ("Not Met"). An overview of the findings for each section follows.

A. Provider Network Adequacy

Home and Community Based Services

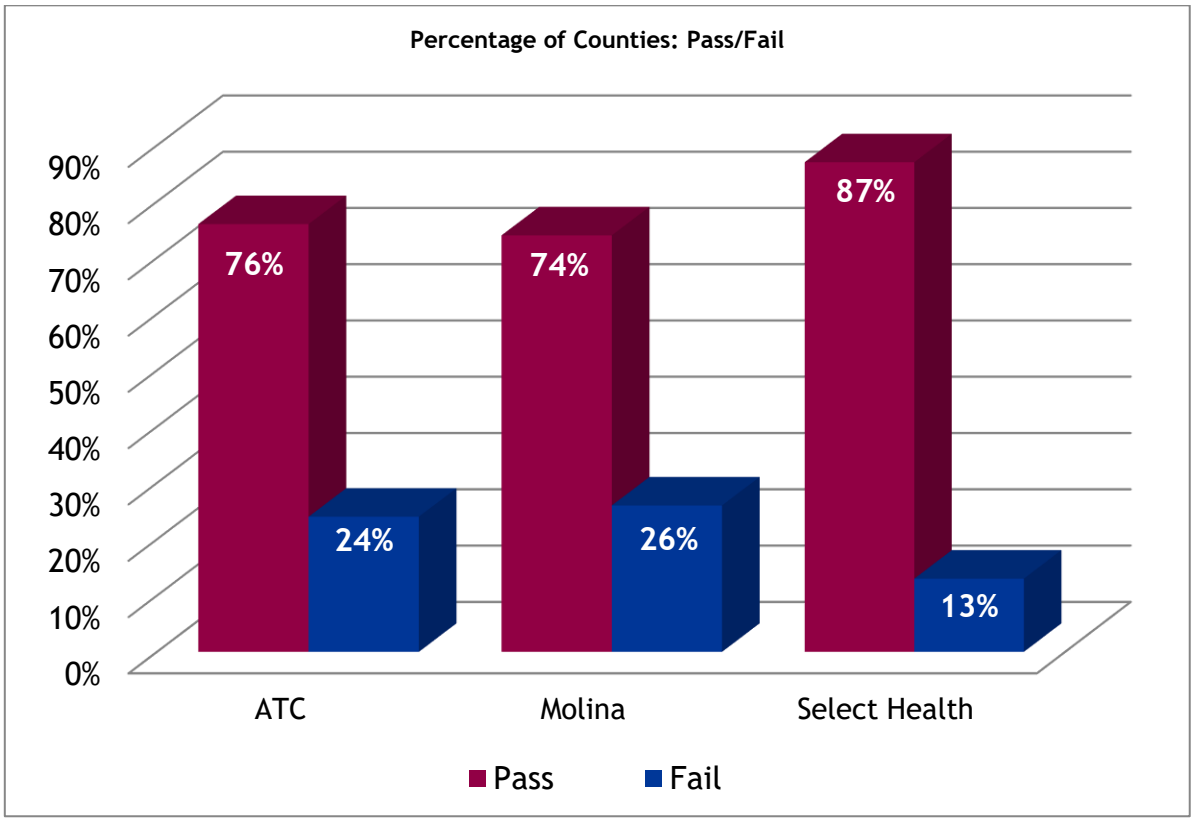
Each CICO submitted a Home and Community Based Services (HCBS) provider file which CCME evaluated to assess provider adequacy. The minimum number of required providers for each active county was calculated and compared to the number of current providers for seven services:

- Adult Day Health
- Case Management
- Home Delivered Meals
- Personal Care
- Personal Emergency Response System (PERS)
- Respite
- Telemonitoring

ATC's review included a total of 35 active counties of a total of 46 counties in SC. Results showed 187 of 245 (76%) required services met the minimum requirement. Molina had the 29 active counties, and 150 services (74%) of 203 had the minimum required number of

providers. Select has 39 total active counties and 237 (87%) of the 273 services met the minimum number of required providers. All three plans earned a "Partially Met" score. The percentage of counties falling into the "Pass" and "Fail" categories are displayed in *Figure 15, HCBS Network Adequacy Review Results*.

Figure 15: HCBS Network Adequacy Review Results



Note: Counties with zero enrollees were not included in pass/fail percentage calculations.

Table 15: Areas Needing Improvement for HCBS Provider Network Adequacy illustrates the network adequacy problematic areas for each plan.

Table 15: Areas Needing Improvement for HCBS Network Adequacy

Plan	Adult Day Health	Case Management	Home Delivered Meals	PERS	Personal Care	Respite	Telemonitoring
ATC		✓	✓	✓	✓		✓
Molina	✓		✓	✓		✓	✓

Plan	Adult Day Health	Case Management	Home Delivered Meals	PERS	Personal Care	Respite	Telemonitoring
Select	✓			✓			✓

None of the plans met the network requirements for PERS and Telemonitoring. Select met most of the services in each county and only lacked providers in the Adult Day Health, PERS, and Telemonitoring categories.

Behavioral Health Network Prover Adequacy

As directed by SCDHHS, CCME used the following criteria to evaluate the network adequacy of behavioral health (BH) providers for each CICO.

- Plans are required to have a network of behavioral health providers to ensure a choice of at least two providers located within no more than 50 miles from any enrollee unless the plan has a SCDHHS-approved alternative time standard. All network providers must serve the target population (i.e., adults aged 65 and older).
- At least one of the behavioral health providers used to meet the requirement for two providers per 50 miles must be a Community Mental Health Center (CMHC). For example, either of the following combinations would meet the minimum requirements:
  - One Community Mental Health Center and one or more of any other listed provider type(s) or
  - Two Community Mental Health Centers
- No other behavioral health provider types are required, though any of the provider types listed may be used as the non-CMHC provider used to meet the two providers per 50 miles requirement.

ATC submitted information for BH providers and CCME compared the information to the requirements set forth by the State. The GeoAccess report provided by Quest Analytics showed 100% of counties have adequate BH provider access and 97.6% of enrollees have access to community mental health centers (CMHC). Several of the 35 serviced counties did not have a CMHC according to the GeoAccess report: Chesterfield, Dillon, Fairfield, Marlboro, Marion, Richland, and Saluda. This report was not consistent with the Excel file submitted by ATC where all counties had one CMHC. Dillon County had only 38% of enrollees with access to a CMHC and Marlboro county had only 17.8% of enrollees with access to a CMHC. The remaining counties without a CMHC showed 100% of enrollees with access to a CMHC, even though one was not present within the county. The standard received a “Met” score with a recommendation to update the BH Provider File to reflect

accurate counts of community mental health centers in each county and determine ways to offer CMHC access to enrollees in Dillon and Marlboro counties.

For Molina, all 29 (100%) counties had a choice of at least two behavioral health providers for members when including adjacent counties. For the CMHC access, 23 of the 29 counties had a CMHC in the primary or adjacent county (79%). The counties that did not have access to a CMHC were Abbeville, Allendale, Barnwell, Edgefield, Hampton, and Saluda. The validation scores were 100% for all BH provider validation and 79% for CMHC provider access validation, which results in a "Partially Met" score.

Select also submitted a file of BH providers used to assess the network adequacy for behavioral health services. The GeoAccess report showed that 98.6% of counties have adequate BH provider access and 100% of enrollees have access to at least one CMHC. Jasper and Georgetown counties do not have 100% BH outpatient access rates. Jasper has two CMHCs, but all members are not located within a 50-mile radius. Georgetown has one CMHC but no BH outpatient providers. The standard received a "Met" score for Select.

Table 16, Provider Network Adequacy Comparative Data provides an overview of each plans score for the Provider Network Adequacy section.

Table 16: Provider Network Adequacy Comparative Data

Standard	ATC	Molina	Select
The CICO maintains a network of Home and Community Based Services (HCBS) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services	Partially Met	Partially Met	Partially Met
The CICO maintains a network of behavioral health (BH) providers in each geographic area that is sufficient to provide all enrollees with access to a full range of covered services	Met	Partially Met	Met

Weaknesses

- None of the plans met the network requirements for PERS and Telemonitoring.
- Enrollees do not always have access to a CMHC within a 50-mile radius.

Recommendations

- Continue enhancing the provision of telemonitoring and PERS by locating providers within the respective service areas.

- Determine ways to offer CMHC access to enrollees in all counties.

B. Evaluation of Over/Under Utilization:

All three CICOs monitor and analyze utilization data to look for trends or issues that provide opportunities for quality improvement. The data submitted included hospital readmission rates, length of star of acute hospitalizations and nursing homes, emergency room utilization, and the percentage of enrollees receiving mental health services.

ATC and Molina present data to Utilization Management Committees for recommendations of any performance improvement and corrective actions if needed. Select analyzes its data and develops action plans and interventions based on analysis of utilization data. All the standards were scored as "Met" as illustrated in *Table 17: Evaluation of Over/Under Utilization Comparative Data*.

Table 17: Evaluation of Over/Under Utilization Comparative Data

Standard	ATC	Molina	Select
The CICO monitors and analyzes utilization data to look for trends or issues that may provide opportunities for quality improvement. Utilization data monitored should include, but not be limited to: 30-day hospital readmission rates for any potentially avoidable hospitalization (enrollees readmitted with a diagnosis of Bacterial Pneumonia, Urinary Tract Infection, CHF, Dehydration, COPD/Asthma, and Skin Ulcers)	Met	Met	Met
Length of stay for hospitalizations	Met	Met	Met
Length of stay in nursing homes	Met	Met	Met
Emergency room utilization	Met	Met	Met
Number and percentage of enrollees receiving mental health services	Met	Met	Met

C. Care Transitions

The CICOs are performing care transition functions to minimize unnecessary complications related to care setting transitions. Communication between the CICOs,

hospitals and other providers was an issue found with the three CICOs. Untimely notifications by facilities of member admissions and discharges caused untimely follow-ups. Collaboration with the member's primary care physician during the transition process was an issue for Molina and Select. All the CICOs are tracking transitions that result in a move to a higher level of care to determine factors that contributed to the change. This analysis is reported to respective committees, so interventions can be taken to improve outcomes. *Table 18: Care Transitions Comparative Data* provides an overview of the CICO's scores in the Care Transitions section.

Table 18: Care Transitions Comparative Data

Standard	ATC	Molina	Select
The CICO conducts appropriate care transition functions, as defined by the CICO 3-Way Contract, Section 2.5 and 2.6, to minimize unnecessary complications related to care setting transitions	Partially Met	Partially Met	Partially Met
Transitions that result in a move to a higher level of care are analyzed to determine factors that contributed to the change and actions taken by the CICO to improve outcomes	Met	Met	Met

Weaknesses

- Untimely notifications by facilities of member admissions and discharges caused untimely follow-ups.
- Collaboration with the member's primary care physician during the transition process was not documented.

Recommendations

- Develop a plan to address communication between the health plan, facilities and providers to improve the timeliness of notifications of admissions and discharges.
- Ensure PCPs and any other applicable external providers are notified of the transition and invited to collaborate with the multidisciplinary team (MT) in the transition planning process. Reflect this process in documentation and files.

D. Quality Improvement Projects

Each CICO is required to submit its PIPs (or QI projects) to CCME annually for review. CCME validates and scores the submitted projects using a CMS designed protocol that evaluates the validity and confidence in the results of each project. The six projects

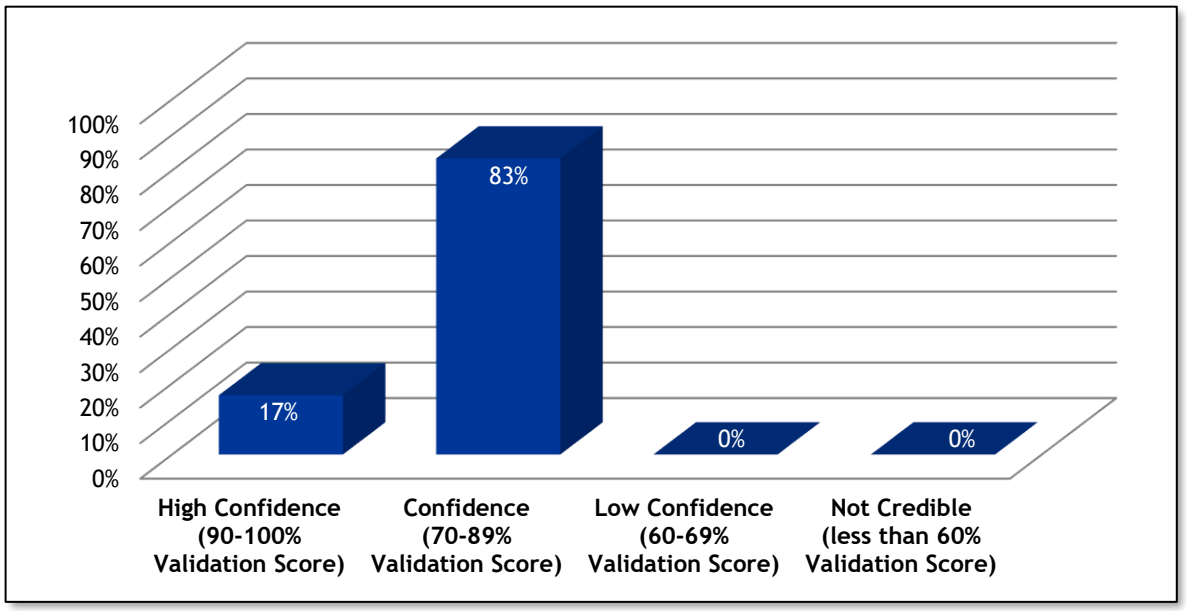
reviewed in 2017-2018 for the three plans are displayed in *Table 19, Results of the Validation of PIPs*.

Table 19: Results of the Validation of PIPs

Project	Validation Score
ATC	
Increasing Flu Vaccine Rates	72% Confidence in Reported Results
Fall Prevention	70% Confidence in Reported Results
Molina	
Flu Vaccine Complete Rate	92% High Confidence in Reported Results
Increasing Caregiver Education, Member Well Being, and Member Quality of Life Among MMP Members	81% Confidence in Reported Results
Select	
Use of Respite Services to Reduce Caregiver Stress	73% Confidence in Reported Results
Improving Flu and Pneumonia Vaccine Rates	81% Confidence in Reported Results

Figure 16: *Percent of Performance Improvement Projects* displays the aggregated validation scores for the PIPs across the three plans. Of the six projects, one (17%) was scored in the high confidence range for Molina. All other projects (83%) were scored in the confidence range. There were no projects considered to be in the low confidence or not credible range. All three plans earned a "Partially Met" score.

Figure 16: Percent of Performance Improvement Projects



Issues for PIPs

CCME found one primary issue across all three CICOs: lack of a clear definition of the measurable indicator(s), baseline, and benchmark. Other issues included alignment of study question with outcome measures, planned data analysis and actual data analysis, lack of information regarding staff/personnel involved in the project, and lack of improvement in the measures of interest. CCME provided recommendations to each plan to improve documentation for the next review cycle. In addition, each plan was referred to the *CMS Protocol, Validation of Performance Improvement Projects* as a guide for the PIP reports.

Table 20: Quality Improvement Projects Comparative Data

Standard	ATC	Molina	Select
The study design for QI projects meets the requirements of the CMS protocol "Validating Performance Improvement Projects"	Partially Met	Partially Met	Partially Met

Strengths

- Topics were chosen based on data analysis and rationale for PIPs was documented.
- Interventions and action plans were documented in PIP reports.

Weaknesses

- PIPs contained issues with definition of measurable outcomes among other issues, such as lack of clear definitions for baseline goal and benchmark rates.

Recommendations

- Adjust PIP reports to follow CMS Protocol for *Validation of Performance Improvement Projects*.
- Utilize the template created by CCME to develop PIP reports.